Maternal and Child Health Services
Title V Block Grant

State Narrative for North Carolina

Application for 2011
Annual Report for 2009

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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications will be maintained on file in the Women's and Children's Health Section Office, located in Room C-7, 5601 Six Forks Road, Raleigh, NC

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input on the MCH Block Grant is obtained in several ways. It is posted on the Women's and Children's Health Section (WCHS) website in July and partnering agencies (including Healthy Start Foundation, March of Dimes state chapter, Area Health Education Centers, etc.) are asked to review it and provide feedback to the Section Office. Another method is sharing portions of the document with members of the Family Council. Ongoing public input is obtained throughout the year as WCHS staff members work with both state and non-governmental agencies to improve programs and services.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The WCHS conceives of priority-setting as a continuous process, in which useful data, both quantitative and qualitative, relevant to the broad mission of the Section are continuously being gathered and analyzed with an eye to adjusting the priorities and the activities of the Section as appropriate. In addition to these day-to-day "micro" analyses of relevant inputs, the Section utilizes formal needs assessment processes, such as the five year needs assessment process, to review and titrate Section priorities and activities.

The WCHS Section Management Team decided to keep the same priority needs as identified in 2005, as these priority needs are very broad and continue to be true needs in the state. These priority needs are as follows:

1. Reduce infant mortality
2. Improve the health of women of childbearing age
3. Prevent child deaths
4. Eliminate vaccine-preventable diseases
5. Increase access to care for women, children, and families
6. Increase the number of newborns screened for genetic and hearing disorders and prevent birth defects
7. Improve the health of children with special needs
8. Improve healthy behaviors in women and children and among families
9. Promote healthy schools and students who are ready to learn
10. Provide timely and comprehensive early intervention services for children with special developmental needs and their families.

There have certainly been changes in the state's strengths, needs, and program and system capacity since the last needs assessment done in 2005. While there did not seem to be huge differences in the health status assessments for any of the population groups between 2005 and 2010, many of the indicators examined seem to be reaching a plateau or worsening somewhat. Infant mortality rates and teen birth rates had been declining, but these appear to be increasing again. There are increases in the number of children and women who are overweight and obese. Immunization rates have dropped.

The need for the services provided by the WCHS does not seem to be waning, but in fact increasing. However, with the economic downturn and the state budget decreases that have occurred over the past few years with no sign of stopping anytime soon, the ability of the WCHS to continue to provide services is hindered. Several programs have been eliminated in the past two years, including the Universal Childhood Vaccine Distribution Program, the Perinatal Outreach Coordination Program, Community Transition Coordinators, Assistive Technology Centers, Hemophilia and Adult Cystic Fibrosis Programs, the Fetal Infant Mortality Review program, the neonatal bed locator, and the Maternal Outreach Worker program. Many programs that may not have been completely eliminated, but reduced, are trying hard to maintain the quality and quantity of services with fewer resources. This is especially true with EI services and the C&Y Branch.

While the full impact of the Affordable Care Act is still to be seen, it does offer the chance of additional resources to provide health services to women, children, and families in North Carolina.

The WCHS is busily working on its Early Childhood Home Visitation Programs and Pregnancy Assistance Fund grant applications and will use information gleaned in the MCH Needs Assessment process in both these applications and any future opportunities.

III. State Overview

A. Overview

In North Carolina (NC), governmental health and social services are generally administered through autonomous county-level governmental agencies. This decentralized structure poses special challenges for design and implementation of statewide programs and initiatives. Priority-setting, decision-making and problem-solving within the Title V program routinely involves use of the extensive network of state-level interagency working groups, and the input of public health workers (and others) at the local and regional level.

The NC Title V program is housed in the Women's and Children's Health Section (WCHS) within the NC Department of Health and Human Services (DHHS) in the Division of Public Health (DPH). The mission of the Department of Health and Human Services is to provide efficient services that enhance the quality of life of North Carolina individuals and families so that they have opportunities for healthier and safer lives resulting ultimately in the achievement of economic and personal independence.

WCHS is responsible for overseeing the administration of the programs carried out with allotments under Title V. The mission of WCHS is to assure, promote and protect the health and development of families with emphasis on women, infants, children and youth. WCHS programs place a major emphasis on the provision of preventive health services beginning in the pre-pregnancy period and extending throughout childhood. The Section also administers several programs serving individuals who are developmentally disabled or chronically ill.

In FY03, the Section Management Team (SMT) held a retreat and defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. The WCHS Core Indicators are as follows:
1. Reduction of Infant Mortality
2. Improved Health of Women of Childbearing Age
3. Prevention of Child Deaths
4. Elimination of Vaccine-Preventable Diseases
5. Increased Access to Care for Women, Children, and Families
6. Prevention of Birth Defects
7. Improved Health of Children with Special Needs
8. Improved Healthy Behaviors in Women and Children and Among Families
9. Healthy Schools and Students who are Ready to Learn
10. All Newborns Screened for Genetic and Hearing Disorders
11. Provision of timely and comprehensive early intervention services for children with special developmental needs and their families.

The state of NC covers 52,175 square miles including 48,710 in land, and 3,465 in water. The 100 counties that compose the state stretch from the eastern coastal plains bordering the Atlantic Ocean, continue through the densely populated piedmont area, and climb the Appalachian Mountains in the west. These diverse geographical features pose a number of challenges to the provision of health care and other social services. In the sparsely populated western counties, there are vast areas of rugged terrain, which make travel difficult especially during the winter months and contribute to the isolation of the rural inhabitants. In the coastal plain counties, which cover almost a quarter of the State, swamp lands, sounds, and barrier islands also contribute to isolation and complicate transportation problems. Moreover, because most local health departments have maintained their single-county autonomy, rural departments are often under-funded and have difficulties attracting sufficient staff and operating efficiently. Although the state is becoming more urban, 64 of the 100 counties are still considered rural.

As of July 2008, NC maintained its position as the tenth most populous state in the nation with an estimated population of 9,222,414. This is an increase of more than three-quarters of a million

people in the past 5 years, a 9.6% increase. Data from the 2000 Census indicate that more than one out of every four individuals in the state is a member of a minority group. African Americans are the largest minority (21.4% of the population), while the combined minorities -- Hispanics (4.7%), Native Americans (1.2%) and Asian/Pacific Islanders (1.4%) -- represent a much smaller percentage. Corresponding percentages for the United States are 68.9% white, 12.9% African American, 12.5% Hispanic, 0.8% Native American, and 2.9% Asian/Pacific Islander. NC is one of seven states in the nation in which African Americans make up over 20% of the population. In addition, NC has the eighth largest Native American population in the United States. There are eight tribes that are recognized by the state; however, only the Federal Government recognizes the Eastern Band of Cherokees.

Because of the importance of agriculture in NC, many seasonal and migrant farm workers are employed in the state. Estimates of these individuals vary depending on the source of data. The Employment Security Commission estimates that there were 37,315 migrants and 24,365 seasonal workers in the state in 2007. Analysis of employment security data indicates that the number of migrant workers and seasonal farm workers has decreased steadily since 2004. Of migrant workers, 98% are Spanish-speaking.

According to US Census data, in 1990, there were 76,726 persons of Hispanic/Latino origin in NC, but by 2000, the number had grown to 378,963 persons -- almost a five-fold increase. By 2007, the US Census Bureau reported that NC had 638,444 persons of Hispanic and Latino ethnicity, a 56 percent increase since 2000. This estimate amounts to just over 7% of the total population in NC in 2007, compared to a national rate of almost 15%. As North Carolina's Hispanic population is disproportionately young and most of the female Hispanic newcomers are in their peak childbearing years, the potential for continued growth of the state's Hispanic population is great. Seventy-one percent of North Carolina's 2007 Hispanic population is under age 35 whereas only 46 percent of the state's non-Hispanic population is in this age range. According to the United States Census Bureau's 2005--2007 American Community Survey, the median age of the state's Hispanic population was 25.6 years, compared to 40.1 years for the white non-Hispanic population of the state. Given the younger age distribution of the Hispanic population, there are unique health issues for this group.

Although the recent downturn in the economy and the post September 11 restrictions on immigration may have slowed down the Hispanic/Latino migration to the state, the relative youth of the population, their high fertility and birth rates, and the increasing numbers of seasonal workers choosing to settle down, indicate continuing significant growth in this population. Their impact on the public health system, particularly on maternal health and family planning programs, will be even more significant in the near future. In the last five years, the number of Hispanic/Latino patients as a proportion of the total family planning patients of the Statewide Family Planning Program has risen to 21%. Similarly in 2008, the proportion of Hispanic/Latino prenatal patients in local maternity clinics was 21.3%. In addition, NC Hispanic births have increased from 2% of the state's births in the early 1990s to 17% in 2007. According to US Census data, of all the states, North Carolina had the second highest percentage increase in Hispanic population between July 1, 2007 and July 1, 2008 at 7.4%. Only South Carolina's increase was higher at 7.7%.

B. Agency Capacity

WCHS is comprised of five Branches: Children & Youth (C&Y Branch), Early Intervention, Immunization, Nutrition Services (including Special Supplemental Nutrition Program for Women, Infants, and Children [WIC]), and Women's Health. The Section Management Team, which is comprised of the Chief, Section Operations Manager, and the five Branch Heads, meets weekly to facilitate joint planning, to keep key staff informed of current activities and issues, and to plan short and long term strategies for addressing current issues. A similar process occurs within the Branches which are responsible for assessing and responding to the needs of its target population(s).

The public health system in North Carolina is not state administered, but there are general statutes in place for assuring that a wide array of maternal and child health programs and services are available and accessible to North Carolina residents. State statutes relevant to Title V program authority are established for several programs administered by WCHS. These statutes include (not an exhaustive list):

GS130A-4.1. This statute requires the NCDHHS to ensure that LHDs do not reduce county appropriations for local maternal and child health services because they have received State appropriations and requires that income earned by LHDs for maternal and child health programs that are supported in whole or in part from State or federal funds received from NCDHHS must be used to further the objectives of the program that generated the income.

GS130A-124. This statute requires NCDHHS to establish and administer the statewide maternal and child health program for the delivery of preventive, diagnostic, therapeutic and habilitative health services to women of childbearing years, children and other persons who require these services. The statute also establishes how refunds received by the Children's Special Health Services Program will be administered.

GS130A-125. This statute requires NCDHHS to establish and administer a Newborn Screening Program which shall include, but not be limited to, the following: 1) development and distribution of educational materials regarding the availability and benefits of newborn screening, 2) provision of laboratory testing, 3) development of follow-up protocols to assure early treatment for identified children, and provision of genetic counseling and support services for the families of identified children, 4) provision of necessary dietary treatment products or medications for identified children as indicated and when not otherwise available, and 5) for each newborn, provision of screening in each ear for the presence of permanent hearing loss.

GS130A-127. This statute requires NCDHHS to establish and administer a perinatal health care program. The program may include, but shall not be limited to, the following: 1) prenatal health care services including education and identification of high-risk pregnancies, 2) prenatal, delivery and newborn health care provided at hospitals participating at levels of complexity, and 3) regionalized perinatal health care including a plan for effective consultation, referral and transportation among hospitals, health departments, schools and other relevant community resources for mothers and infants at high risk for mortality and morbidity.

GS130A-129-130. These statutes require NCDHHS to establish and administer a Sickle Cell Program. They require that LHD provide sickle cell syndrome testing and counseling at no cost to persons requesting these services and that results of these tests will be shared among the LHD, the State Laboratory, and Sickle Cell Program contracting agencies which have been requested to provide sickle cell services to that person. In addition, these statutes establish the Council on Sickle Cell Syndrome, describing its role and the appointments, compensation, and term limits of the council members.

GS130A-131.8-9 These statutes establish rules regarding the reporting, examination, and testing of blood lead levels in children. Statutes 131.9A-9G include requirements regarding the following aspects of lead poisoning hazards: 1) investigation, 2) notification, 3) abatement and remediation, 4) compliance with maintenance standard, 5) certificate of evidence of compliance, 6) discrimination in financing, 7) resident responsibilities, and 8) application fees for certificates of compliance.

GS130A-131.15. This statute requires NCDHHS to establish and administer an Adolescent Pregnancy Prevention Program. The statute describes the management and funding of the program including the application process, proposal requirements, operating standards, criteria for project selection, schedule of funding, and funding limitations and levels.

GS130A-131.16-17. These statutes establish the Birth Defects Monitoring Program within the State Center for Health Statistics. The program is required to compile, tabulate, and publish information related to the incidence and prevention of birth defects. The statutes require physicians and licensed medical facilities to permit program staff to review medical records that pertain to a diagnosed or suspected birth defect, including the records of the mother.

GS130A-152-157. These statutes establish how immunizations are to be administered, immunization requirements for schools, child care facilities, and colleges/universities, and when and how medical and religious exemptions may be granted.

GS130A-371-374. These statutes establish the State Center for Health Statistics within NC DHHS and authorize the Center to 1)collect, maintain and analyze health data, and 2) undertake and support research, demonstrations and evaluations respecting new or improved methods for obtaining data. Requirements for data security are also found in the statutes.

GS130A-422-434. These statutes establish the Childhood Vaccine-Related Injury Compensation Program, explain the Program requirements, and establish the Child Vaccine Injury Compensation Fund.

GS130A-440-443. These statutes require health assessments for every child in this State entering kindergarten in the public schools and establish guidelines for how the assessment is to be conducted and reported. Guidelines for religious exemptions are also included.

Using federal Title V funds and other funding sources, WCHS must contract with local health departments (LHDs) and other community agencies to assure that these services are available. There are 85 LHD clinics which provide clinic and preventive services in all 100 counties. In addition, there are many community health centers and other agencies providing services. Each contract contains a scope of work or agreement addenda that specifies the standards of the services to be provided. The public health departments, which have local autonomy, have a long-standing commitment to the provision of multidisciplinary perinatal, child health, and family planning services, including medical prenatal care, case management, health education, nutrition counseling, psychosocial assessment and counseling, postpartum services, child service coordination, well-child care, and primary care services for children.

A wide range of preventive health services are offered in virtually all LHDs, allowing most clients to receive a continuum of reproductive health services at a single site. Standards for provision of WCHS supported prenatal and postpartum services are based on the American College of Obstetrics and Gynecology (ACOG) guidelines. These standards have been revised to be consistent with best practices derived from the current scientific literature as well as with the relevant NC regulations and are provided in soon to be published Maternal Health Resource Manual. They are also generally quite consistent with the new fourth edition of the American Academy of Pediatrics/American College of Obstetricians and Gynecologists' Guidelines for Perinatal Care. Because of this consistency with these nationally recognized guidelines, there is a good case to be made that these standards should also provide the basis for standards for the prenatal care provided by Medicaid managed care and ultimately commercial managed care agencies. Local health agencies receiving Title X funding to provide family planning services must abide by the January 2001 Program Guidelines for Project Grants for Family Planning Services and the subsequent Title X Program Instruction Series developed by the Office of Population Affairs (OPA), US DHHS.

Consultation and technical assistance for all contractors is available from WCHS staff members with expertise in nursing, social work, nutrition, health education and medical services. Staff includes regional child health and women's health nursing and social work consultants who routinely work with agencies within assigned regions.

Additional Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

High Risk Maternity Clinics (HRMCs) - In order to achieve the WCHS goal of risk-appropriate prenatal care, the Section also supports HRMCs across the state. The "traditional" HRMCs, located at tertiary care centers, are supervised by Maternal-Fetal Medicine specialists with immediate access to state-of- the-art technical support services and subspecialty consultation. These clinics have true regional catchment areas and function as "end providers." They are equipped to handle the highest risk prenatal clients without need for referral to higher levels of care. The remaining three HRMCs are housed in larger health departments, and are generally staffed by local obstetricians. They do not draw from a regional catchment area and refer the highest risk clients to the tertiary centers for care. At the time of the inception of the HRMC program, the LHD HRMCs were pioneers in the provision of multidisciplinary care and also filled in some gaps where intermediate level care was somewhat inaccessible. As time has passed, the multidisciplinary care model they pioneered has been widely adopted, at least in the public sector, and the tertiary center network in the State has matured. The future role of these "intermediate level" HRMCs is unclear. As part of its charge to provide technical assistance and oversight to this network of clinics, WCHS continues to assess what changes are needed in the program to achieve the goal of risk-appropriate services for all pregnant women.

Maternity Care Coordination (MCC)- This program is the cornerstone of the state's attempts to eliminate barriers to prenatal care service provision. MCC services are provided by a nurse or a social worker whose primary role is to help clients access and effectively utilize services that address medical, nutritional, psychosocial and resource needs, while providing emotional support. The majority of MCCs are based in LHDs, but an increasing number are being based in private prenatal provider offices. WCHS provides start-up funding to local providers of support services to encourage them to hire additional care coordinators in order to increase the percentage of Medicaid clients who receive care coordination. WCHS also administers a limited amount of state appropriations which categorically support the provision of care coordination services to clients ineligible for Medicaid. LHDs are free to allocate portions of the block granted federal and state funds they receive to provide MCC or other support services to clients ineligible for Medicaid.

Minority Infant Mortality Reduction Efforts - The Healthy Beginnings (Minority Infant Mortality Reduction) Program was established in 1994 to provide funding to community-based organizations that developed programs to reduce infant mortality and low birth weight births among minority populations in North Carolina. In an order to strengthen community-based efforts to address perinatal health disparities, and thereby improve birth outcomes among communities of color, the Targeted Infant Mortality Reduction (TIMR) program has merged with the Healthy Beginnings Program. Community based organizations and LHDs with experience working in minority communities are eligible to apply for Healthy Beginnings funding. Funding is available for 3 years, contingent upon performance. Between 10 and 14 sites are funded at an award level of $75,000 to $100,000 annually. Grant recipients are expected to implement programs that will impact the reduction of minority infant mortality and low birth weight births in their communities and thereby improve minority birth outcomes. Funded agencies are expected to provide the following to minority pregnant women (or women within the 60 day post partum period):
-Case management/care coordination;
-Health education and support which includes education in the following areas: breastfeeding initiation and maintenance up to at least 6 weeks, eliminating use and exposure to tobacco, safe sleep, folic acid consumption, reproductive life planning, healthy weight and exercise;
-Ensure well child visits and proper immunizations for their babies;
-Outreach; and
-Work with their male partners when applicable.

Baby Love Plus - The NC Baby Love Plus Program serves African American and Native American pregnant women enrolled in the Baby Love MCCP and receiving care at a project area LHD or pre-determined clinic. The NC Baby Love Plus program is one of the federally funded Healthy Start infant mortality reduction projects designed to focus on eliminating racial disparities.

While each of the programs is designed to serve a specific geographic region (Northeastern, Triad, or Eastern counties), they collectively serve pregnant and parenting families through the following core components: outreach, case management, interconceptional care, depression screening, strengthening perinatal systems of care, and local consortium development. The Northeastern Project also has a focus on the prevention of family violence during and around the time of pregnancy.

The NC Baby Love Plus Program partners with the LHDs for implementation of the program. LHD staff members carry out the outreach and case management efforts. Local staff includes Community Health Advocates and Family Care Coordinators. Approximately 120,000 women are served through this program. Baby Love Plus also subcontracts with community and faith-based organizations that provide support services and education to women of childbearing age (15-44 years), infants, fathers/male partners, and families in areas including health promotion, healthy life styles, parenting, safe sleep practices, and fatherhood development.

Teen Pregnancy -- In addition to family planning services for all women of childbearing ages, the FPRHU also manages the Teen Pregnancy Prevention Initiative (TPPI). The initiative, which was funded with state appropriation beginning in 1989, initially supported programs designed to prevent first pregnancies among high-risk youth in specifically targeted communities. A unique component of this program is a legislatively mandated requirement for funded programs to conduct outcome evaluations. Over time, results of the evaluations have enabled TPPI staff not only to identify "best practice" models in primary pregnancy prevention, but also be more prescriptive in their guidance to prospective and currently funded programs. In the FY11 application cycle, TPPI staff prescribed 9 best practice models. Applicants are strongly encouraged, though not required, to use the prescribed models. However, all TPPI projects are required to participate in an ongoing evaluation using a web-based system administered by the state Office of Information Technology Services.

The second major component of the TPPI program is a secondary prevention model initially implemented by the NC Division of Social Services (DSS) in 1984, eventually transferred to DPH in 1998 and then subsumed under the TPPI umbrella. While the primary focus of the Adolescent Parenting Program (APP) is in reducing subsequent unintended pregnancies among pregnant/parenting teens, it is also focused on promoting parenting skills, preventing child abuse and neglect, and ensuring high school graduation among its participants.

In FY10, the FPRHU funded 53 TPPI projects in 28 secondary prevention and 25 primary prevention sites in 38 North Carolina counties. The FPRHU contracts with a variety of agencies including not-for-profit community based and faith-based organizations, as well as LHDs and schools, to implement activities and strategies to reduce unintended teen pregnancies. Although the programs predominantly serve at risk adolescent females ages 10-18, several funded projects focus on males.

In response to the rapidly growing Latino population in the State, the TPPI program continues to seek additional funding to support Latino teen pregnancy prevention initiatives. In FY06, the TPPI program implemented an Annie E. Casey initiative Plain Talk (Hablando Claro), a neighborhood-based initiative aimed at helping adults, parents and community leaders develop the skills and tools they need to communicate effectively with young people about reducing adolescent sexual risk-taking. Additionally, ¡Cuidate! (Take Care of Yourself), a primary prevention model aimed at reducing sexual risk among Latino youth, is among the science-based best practice models recommended by TPPI for the FY11 funding cycle. TPPI is able to address ethnic and racial disparities by collaborating with private foundations, federal grantees agencies, local government, and local Latino advocacy groups to support initiatives that address the reduction of unintended teen pregnancies among Latino teens.

Additional Preventive and Primary Care Services for Children

WCHS provides preventive health services to children from birth to 21 years of age primarily through LHD clinics. The schedule of recommended visits is based on Bright Futures guidelines. Normally, clinic services are not provided for acutely ill children, although some health departments do provide pediatric primary care. Nurse screening clinics are conducted by public health nurses in LHDs. Physicians do not staff these clinics; however, services are provided under the guidance of the physician who attends the pediatric supervisory clinic. Medical management includes written policies and procedures that are updated regularly. Public Health Nurse Screeners receive specialized training for this role through a training program sponsored by the C&Y Branch. Nurse screening clinic services include: parental counseling regarding good health, nutrition practices and developmental milestones; immunizations; assessment of proper growth, development, hearing, vision, and speech; screening for anemia and lead; and referrals as needed. Pediatric clinics are conducted by physicians (family practitioners and/or pediatricians), nurse practitioners, and/or physician assistants. They serve as referral clinics for children with problems identified in nurse screening clinics. Pediatric clinic staff make referral for specialty consultations as needed.

The purpose of the Health Check (HC) program is to facilitate regular preventive medical care and the diagnosis and treatment of any health problem found during a screening for children eligible for Medicaid and under the age of 21. Health Check Coordinators (HCC) play a vital role in outreach efforts and assuring that Medicaid recipients access preventive health screenings. The HCC use an Automated Information and Notification System (AINS) to track and follow Medicaid eligible children. This system has the ability to generate personalized reminder and missed appointment letters based on paid claims data. The HCC make direct contact with clients via telephone calls, additional personalized letters, and occasional home visits. The type and results of their contacts are recorded in the comment section of the database. They work closely with the managed care representatives at local departments of social services to ensure children are connected with their primary care provider for continuity of care. In addition, they work closely with the provider community to ensure children receive regular preventive health care and follow-up for conditions that have been referred to a specialist.

NC Health Choice for Children (NCHC), the child health insurance program in NC, is a federal and state partnership to provide comprehensive health insurance to uninsured children. It provides free or low cost health insurance to children whose families cannot pay for private insurance and who do not qualify for HC. Children with special health care needs are eligible to receive additional benefits under NCHC. This program is administered jointly by DMA and DPH, with DMA providing oversight for the program and establishing eligibility policy and DPH being responsible for outreach efforts and for services to children with special health care needs. Outreach to potentially eligible families is coordinated by Outreach Coalitions in each county. WCHS supports the efforts of the local coalitions by providing tools such as print materials, electronic media pieces, monthly coalition updates, consultation and technical assistance, workshops, and outreach to state and regional organizations.

Session Law 2005-276 by the NC General Assembly (NCGA) mandated the NCHC program to limit participation to eligible children ages 6 through 18 beginning January 1, 2006. This session law also mandated the Medicaid program to provide coverage for children birth through the age of five with family incomes equal to or less than 200 percent of the federal poverty level beginning January 1, 2006. As a result of this legislation, current NCHC children ages birth through five were moved to the HC program on January 1, 2006. In addition, the NCGA capped NCHC enrollment growth to 3% every 6 months and reduced NCHC reimbursement rates to 115% of the HC fee schedule on 1/1/2006 and 100% on 7/1/2006. The NCGA also directed DHHS to move NCHC children (ages 6 through 18) into the Community Care of NC networks for case management services. WCHS worked closely with DMA to assure a smooth transition for NCHC children to Health Check. This involved drafting notices/letters to families and preparing a bulletin/list serve notices for providers to prepare for transition issues related to prior approval, hospital coverage, etc.

School Health Matrix Team - The School Health Matrix Team was created in FY04 to enhance the effectiveness of DPH programs that target the school age population, and/or focus on services available in or for schools. The DPH Matrix Team works in close collaboration with the Department of Public Instruction (DPI) to improve the health and academic achievement of students by supporting the development of and strengthening school health programs and policies across the state. The Matrix Team allows the DPH to effectively utilize staff across Branch and Section lines to create a multi-disciplinary, multi-agency focus on school health. The Section Chiefs for Oral Health, WCH, and Chronic Disease and Injury provide overall guidance in program planning, marketing, and implementation of services and to help build capacity for school health services.

Early Childhood Comprehensive System - In 2004 the Division of Public Health obtained the support of NC DHHS Secretary for use of the State Early Childhood Comprehensive Systems (ECCS) grant as a core vehicle for increasing coordination and collaboration within and outside the department with respect to early childhood issues. NC's ECCS Implementation Plan was created by a multi-agency state-level partnership that met throughout the ECCS planning period and agreed to develop a plan for a comprehensive, integrated early childhood system that supports school readiness and builds on existing efforts and initiatives.

The vision for the ECCS Plan was intentionally created to be consistent with the visions of established early childhood partners, e.g., the NC Partnership for Children (Smart Start), NC's SPARK initiative (funded by the Kellogg Foundation), so that it could serve as a bridge rather than a barrier in system-building efforts. As stakeholders focused on the fact that there are multiple and interacting factors affecting child outcomes, the need for engagement across systems (health, early care and education, families, etc.) became a primary objective of the planning process.

The goals of the ECCS Plan are:
1.Share accountability for an effective, comprehensive, and integrated early childhood system in NC in a multi-agency state-level partnership.
2.Use a set of shared indicators for school readiness to evaluate success at all levels of the early childhood system.
3.Develop a shared early childhood data system.
4.Infuse the early childhood system with people who have core competencies in early childhood (based in developmental science) as well as the practical approaches and community relationships necessary to provide effective services to children and families.
5.Foster a philanthropic and government consortium to nurture and build state and local partnerships.
6.Secure the commitment of families, stakeholders, and decision makers about the costs, benefits, and consequences of building or neglecting a comprehensive, integrated early childhood system.
7.Improve our systems of care by using evidence-based practices to positively affect child outcomes for all critical components of a comprehensive early childhood system.

North Carolina's ECCS Plan was created during the planning phase (9/1/03 -- 8/31/05) of the ECCS grant. During the first four years of the implementation phase (9/1/05 -- 05/31/09), stakeholders were successful in implementing a number of strategies outlined in the original ECCS plan. In the current phase of the grant program (6/09 -- 5/10), ECCS grant resources are focused on further development of a comprehensive leadership structure that that shares accountability for an effective system and for child outcomes. Governor Beverly Purdue is taking steps to create an Early Childhood Advisory Council as required in the Head Start Reauthorization Act of 2007. The ECCS Grant Coordinator is serving on the Early Childhood Advisory Council Work Group to support efforts to develop the Council.

Services for Children with Special Health Care Needs (CSHCN)

Children's Special Health Services (CSHS) is a state-administered program, financed by both federal and state funds. Care is provided through a network of professionals in the private section, clinics, hospitals, schools, and community agencies. All aspects of patient care are addressed, including assessment, treatment, and follow-up. CSHS provides cardiology, neurology, neuromuscular, oral-facial, orthopedic, myelodysplasia, speech/language and hearing services. In addition to providing diagnostic and treatment services through CSHS-sponsored clinics, the program also reimburses limited services for eligible children on a fee-for-service basis. Covered services include hospitalization, surgery, physicians' care, laboratory tests, physical, occupational and speech therapy, medication, durable medical equipment, orthotics and prosthetics, medical supplies and other interventions. In addition to specialty clinic services, selected "wrap-around" services are funded for Medicaid-eligible children on a fee-for-service basis. CSHS is reimbursed by Medicaid for provision of most of these services, which include hospitalization; physicians' care; laboratory tests; physical, occupational and speech therapy; medication; durable medical equipment; orthotics and prosthetics; medical supplies; and other interventions.

The WCHS continues to be committed and guided by the key principles of comprehensive, community based, coordinated and family-centered care. There have been dramatic changes at the state and community level among key collaborators such as Early Intervention, Mental Health/Substance Abuse/Developmental Disability, School Health, and the private and public health care financing and delivery system, as well as significant shifts in priorities and resource allocation in DPH. In response, the CSHCN program has continued to review and critically evaluate all aspects of the program. The process has been directed by key personnel within CSHCN, in conjunction with a strengthened Family Council, the Commission for CSHCN, and other representatives from key constituency groups. Driven by considerations to improve the efficiency and effectiveness of services, while concurrently developing strategies reflective of a family-centered approach, the CSHCN program is being reorganized both centrally and regionally in WCHS, as well as in relation to community partners. The early evidence is that this will result in improved collaboration and coordination. Of equal importance, the objective to better integrate services and supports for children with special health care needs into all aspects of C&Y Branch initiatives is being strongly pursued.

Child Service Coordination (CSC) -The purpose of the CSC program is to identify and provide access to preventive and specialized support services for children and their families through collaboration. Children are eligible for the CSC program if they are at risk for, or have a diagnosis of developmental delay or disability, chronic illness, or social/emotional disorder. In the CSC program, a service plan for the child/family is developed based on an assessment of the families identified strengths, needs and concerns. Coordinators work with other health and social services providers to monitor the child's development, strengthen parent-child interactions, foster family self-sufficiency, provide information about available programs and services, assist with application forms, and/or help to locate desired and appropriate resources. Follow-up contacts are required at least monthly; however, the frequency is actually based on family ability and need. Children from birth to age three who meet one of the definitions of the program Risk Indicators and children from birth to five who meet one of the definitions of the program Diagnosed Conditions are eligible. There are no income eligibility requirements for the CSC Program.

Newborn Screening Services - The universal newborn metabolic screening services were initiated in North Carolina in 1966 with services for phenylketonuria. Tandem mass spectrometry was begun in July 1977 and as of 2009, North Carolina screens for all of the nationally recommended conditions with the addition of Biotinidase deficiency. The newborn metabolic screening samples and newborn hearing screening results are obtained simultaneously at birthing hospitals in North Carolina and reported through the same screening form. Follow-up is conducted on all newborns with a confirmed condition.

Neonatal Hearing Screening - Hearing screening has been mandatory for all infants born in NC as of October 1, 1999. Screening equipment was provided to 60 birthing hospitals through a

special project of WCHS. The tests are performed quickly while babies are asleep. Audiologists affiliated with C&Y Branch Speech and Hearing Teams provide technical assistance to the hospitals and also perform infant hearing screenings and diagnostic assessments for older children.

The School Based Child and Family Support Team Initiative was begun during FY06. Its mission is to provide appropriate family-centered, strengths-based community services and supports to those children at risk of school failure or out-of-home placements as a result of the physical, social, legal, emotional, and developmental factors that affect their academic performance. While the staff person for the Initiative reports directly to the Secretary of DHHS, he is housed in the C&Y Branch and collaborates with branch members on this project. Through the Initiative, all State and local child serving agencies will collaborate and communicate to share responsibility and accountability to improve outcomes for at-risk children and their families. In 100 schools located in 21 Local Education Agencies across the State, Child and Family Support Team Leaders (a school nurse and social worker team in each school) will identify and coordinate appropriate community services and supports for children at risk of school failure or out-of-home placement in order to address the physical, social, legal, emotional, and developmental factors that affect their academic performance. These services are necessary so that those at-risk children may succeed academically, live in safe, nurturing and permanent families, and have opportunities for healthier and more stable lives.

C. Organizational Structure

DHHS is a cabinet-level agency created in October 1997 when the health divisions of the Department of Environment, Health and Natural Resources (DEHNR) were combined with the existing Department of Human Resources (DHR). Lanier M. Cansler was appointed as Secretary of DHHS by Governor Beverly Perdue in January 2009. Serving as State Health Director and Division Director for DPH since March 2009 is Dr. Jeff Engel. Dr. Engel served as the State Epidemiologist beginning in 2002. In 2006, he was named Chief of the Epidemiology Section of the Division.

The Department is divided into 32 divisions and offices which fall under four broad service areas -- health, human services, administrative, and support functions. Divisions and offices include: Aging and Adult Services; Budget and Analysis; Child Development; Citizen Services; Controller; Council on Developmental Disabilities; Economic Opportunity; Education Services; Environmental Health; General Counsel; Government Relations; Health Service Regulation; Human Resources; Information Resource Management; Internal Audit; Medicaid Management Information Systems; Medical Assistance; Mental Health, Developmental Disabilities, and Substance Abuse Services; Privacy and Security Office; Procurement and Contract Services; Property and Construction; Public Affairs; Public Health, Rural Health and Community Care; Secretary's Office; Services for the Blind; Services for the Deaf and Hard of Hearing; Social Services; State Center for Health Statistics; State Operated Healthcare Facilities; Vital Records; and Vocational Rehabilitation. DHHS also oversees 18 facilities: developmental disability centers, psychiatric hospitals, neuromedical treatment centers, alcohol and drug abuse treatment centers, schools for the deaf and blind, and early intervention programs.

DPH is comprised of the Director's Office and ten other offices and sections: Administrative, Local, and Community Support; Chronic Disease and Injury; Epidemiology; Human Resources; Office of Minority Health and Health Disparities; Oral Health; State Center for Health Statistics; State Laboratory of Public Health; Vital Records; and WCHS.

Kevin Ryan, Section Chief, is the Title V Program Director and Carol Tant, Children and Youth Branch Head, is the CSHCN Program Director. WCHS is responsible for overseeing the administration of the programs carried out with allotments under Title V and for other programs including family planning, early intervention, nutrition services (including the state WIC program), and immunization. WCHS has a history of sound management practices and oversight involving

grants and contractual funds. It administers hundreds of grants and contracts each year in a capable and professional manner. WCHS uses a sub-recipient monitoring system established by DPH. This system rates each contractor's performance, and includes corrective action protocols for low performing contractors. Such contractors receive additional monitoring and site visits in order to develop and implement an improvement plan. To date, no deficiencies have been noted in any internal or external audit, review or report on the Division's financial management system.

An organizational chart for DHHS and DPH is attached.

An attachment is included in this section.

D. Other MCH Capacity

The Section oversees and administers an annual budget of over $528 million and employs 1,166 people. This is 55% of the DPH staff, along with 68% of the budget. The WCHS's broad scope promotes collaborative efforts while discouraging categorical approaches to the complex challenge of promoting maternal and child health. The Section is committed to ensuring that services provided to families are easily accessible, user-friendly, culturally appropriate, and free from systemic barriers that impede utilization. While many staff members work in the central office in Raleigh, there are a number of regional consultants who work from home-based offices. In addition, the Early Intervention Branch has a network of 18 Children's Developmental Services Agencies (CDSAs) serving all 100 counties.

Key Staff Members

Section Chief - Dr. Kevin Ryan became the Title V Director in March 1999. He had served as Chief of the Women's Health Section (now Women's Health Branch) since 1991. Dr. Ryan graduated from the University of California at Davis Medical School and completed a residency in Obstetrics and Gynecology at the University of Arizona Health Sciences Center in Tucson, Arizona. After completing his residency in 1986, he became an Assistant Professor in the Department of Obstetrics and Gynecology and then began a private practice in obstetrics and gynecology. He completed an MPH from the UNC School of Public Health, Department of Maternal and Child Health in 1991. Since his graduation he has maintained an active relationship with the Department, and has served as Adjunct Assistant and then Associate Professor.

Section Business Operations Manager - Peter Andersen assumed this position in March 2001. Mr. Andersen has a master's degree in Health Education from the University of Virginia (1976) and a Master of Business Administration from Delaware State University (1989). He has been in the public health field for over 20 years. The first eleven were with the Delaware Division of Public Health in a variety of chronic disease program management positions. His eight previous years with the North Carolina state health agency have been in positions in health promotion and chronic disease prevention.

Women's Health Branch Head - Dr. Joe Holliday replaced Dr. Kevin Ryan as Women's Health Branch Head in February 2000. Dr. Holliday has over 30 years of public health leadership experience, including local health director positions in Virginia, South Carolina and North Carolina. Previous Division of Public Health duties included: program manager for the Comprehensive Breast and Cervical Cancer Control and Wise Woman Programs; and Chief of the Chronic Disease Prevention and Control Branch. He is a graduate of University of North Carolina at Chapel Hill, Vanderbilt School of Medicine, and the UNC School of Public Health (Department of Maternal and Child Health). He also completed a pediatric internship from Pittsburgh Children's Hospital and a preventive medicine residency from the School of Medicine, University of North Carolina.

Children and Youth Branch Head - Carol Tant became Branch Head in February 2000. She has an undergraduate degree in psychology, and earned her MPH in health administration from the

UNC School of Public Health in 1980. She worked in increasingly responsible positions in mental health, women's health, and children's health services. Carol's work experience in children's health for over 25 years has included positions in genetics, specialized services and preventive health at both the regional and state levels.

Nutrition Services Branch Head - Alice Lenihan earned a BS in food and nutrition from the College of St. Elizabeth (New Jersey, 1970), and a MPH in health administration from the UNC School of Public Health in 1983. After gaining local and regional experience in WIC programs, she was appointed state WIC Director in 1984. She continues to serve in that capacity as Nutrition Services Branch Head. In addition to the WIC program, she has oversight of the state's Child and Adult Care Feeding Program, Summer Food Service Program, and Nutrition Education and Training Program.

Immunization Branch Head - Beth Rowe-West assumed the position of Branch Head in December 1999 after serving in an acting capacity since October 1998. She earned her BS in Nursing from the University of North Carolina at Greensboro and has worked most of her career in public health, serving 11 years in a local health department prior to coming to the Immunization Branch as the Hepatitis B Coordinator in 1994.

Early Intervention Branch Head - Deborah Carroll assumed the position of Branch Head in March 2005. She received a BS in Speech Pathology from Appalachian State University, a MA in Speech Pathology-Audiology from UNC Greensboro and a PhD in Human Development and Family Studies from UNC Greensboro. She is licensed and board certified in Audiology. She worked from 1999 to 2003 in the EI Branch as Director of EI's Comprehensive System of Personnel Development. Most recently she was the Unit Manager of the Genetics and Newborn Screening Unit of the C&Y Branch of the WCHS.

Data Specialist/Needs Assessment Coordinator (State Systems Development Initiative Project Coordinator) - Sarah McCracken Cobb began working in this position on July 1, 2000. She completed her undergraduate degree in chemistry at the University of North Carolina at Chapel Hill in 1987 and earned an MPH from Boston University in 1989. After serving in the US Peace Corps, she has held assessment positions with the state health agency in HIV/AIDS, immunization, and maternal health programs.

Family Liaison Specialist - During FY04, the C&Y Branch filled the Family Liaison Specialist position by a family member of an adolescent with special needs, Marlyn Wells. She serves as staff to the Family Council, which works extensively with the staff of the C&Y Branch. She trains, assists and advises staff on the development and promotion of family related issues and activities such as family perspectives, family centered care, care coordination, transition planning, medical home and educational/community resources. She also advises WCHS families on an as-needed basis on issues related to children with special needs.

Pediatric Medical Consultant for the C&Y Branch -- Dr. Gerri Mattson joined WCHS in this capacity in August 2005. She received her MD from the Medical College of Virginia in 1993, completed her internship and residency at Emory University in 1996, and received her MSPH from the School of Public Health at UNC in 2004. Her expertise is available to a wide range of public and private providers on best and promising practices in policy, program development, and evaluation related to child and adolescent health. She also works with staff members of other branches in WCHS as necessary. She has almost 18 years of experience in a variety of pediatric health care and public health settings.

E. State Agency Coordination

With creation of DHHS in October 1997, state-level public health, mental health, social services, Medicaid, child welfare, vocational rehabilitation, substance abuse, and child development

programs are now administered from a single agency. The DHHS Secretary has weekly meetings of the directors of these programs. These serve as a forum for discussing common issues and for facilitating coordination of efforts. The DHHS Deputy Secretary for Health Services conducts regular meetings with the directors of the divisions and offices that he manages (Public Health; State Operated Healthcare Facilities; Office of Minority Health and Health Disparities; Division of Medical Assistance; Office of Rural Health and Community Care; Division of Health Services Regulation; and Mental Health, Developmental Disabilities, and Substance Abuse Prevention) Thus, intra-agency coordination is expected and facilitated at all levels of the organization. In addition, the Division is signatory to formal written agreements with several agencies, including:
-DHHS Division of Medical Assistance (DMA) for provision of Medicaid reimbursed services for the MCH population. The current agreement includes a wide array of services and defines joint responsibility for informing parents and providers of the availability of MCH and Medicaid services. This agreement is revised in its entirety every five years, with interim changes as needed.
-DPI (state education agency) for assuring the provision of multidisciplinary evaluation, special therapies, health and medical services, and service coordination. This agreement is updated every three years and meets the requirements of the Individuals with Disabilities Act (PL 102-119).
-DHHS Office of Research, Demonstrations and Rural Health Development (formerly Office of Rural Health and Resource Development). The state primary care agreement outlines the Division's relationships with community health centers and other primary care providers.
-DHHS Division of Vocational Rehabilitation Under this agreement, the Division assumes responsibility for informing families of the availability of Supplemental Security Income (SSI), eligibility determination (when appropriate) and assurance that children remain under care.
-DHHS Division of Child Development This agreement specifies collaboration in three areas: child care health and safety training calendar; a monthly family child care health bulletin; and support for the child care health specialist position that responds to health and safety issues through the 1-800-CHOOSE1 hotline. The hotline gives access to the resource center which provides training, technical assistance and information to child care health consultants, child care providers, and consumers. WCHS also is an active member of the Advisory Committee on Public Health Issues and Child Care.

The plan for coordination of the Title V program with the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), other federal grant programs (including WIC, related education programs, and other health, developmental disability, and family planning programs), and providers of services to identify pregnant women and infants who are eligible for Title XIX is described in Section A. Agency Capacity.

WCHS staff assure that information about health and social services is available to the target population by supporting the following toll-free information and referral hotlines:
-MCH Hotline - NC's Family Health Resource Line (1-800-FOR-BABY or 1-800-327-2229) has evolved from a prenatal care hotline to a multi-program resource. The hotline averages 3,500-4,000 calls a month and operates 24 hours a day, including holidays. In December 2009, the Family Health Resource Line became an automated system to triage calls and forward them to existing call centers based on the choices made by the caller. This change in service was prompted by a State budget crisis that required consolidation of existing hotline services. Calls relating to maternal and child health issues, family health, Health Check (Medicaid for Children) and NC Health Choice (North Carolina's Children's Health Insurance Program) are routed directly to the CARE-LINE, North Carolina Department of Health and Human Services' (NCDHHS) toll-free Information and Referral telephone service. Staff members provide information, advocacy and referrals for primary and preventive health services for children and youth and provides general perinatal information with special emphasis on reaching pre-conceptional and pregnant women.
-CARE-LINE (1-800-662-7030) provides general information about available social services.
-CSHCN Help Line (1-800-737-3028) provides information about genetic services and services for children with special health care needs.

-Family Support Network (1-800-TLC-0042) provides information about special health problems and the availability of services for children with special health care needs. (Meets Individuals with Disabilities Education Act [IDEA] requirements.)

DPH and WCHS staff work with DPI on a number of projects including a Centers for Disease Control and Prevention (CDC) funded grant to improve interagency coordination of health services offered by health and education agencies (CDC "infrastructure" grant), and nutrition programs. In addition, WCHS provides leadership, consultation and technical assistance to the state education agency and local school districts for:
-Development and maintenance of school-based and/or school-linked health centers,
-Expansion and enhancement of school nurse services,
-Nutrition and related training for food service workers, and
-Implementation of US Department of Agriculture (USDA)-funded summer food and nutrition programs.

Close working relationships are maintained with the UNC School of Public Health, particularly with its Department of Maternal and Child Health. Division staff members serve as adjunct faculty members and are frequent lecturers in the Department, in addition to serving on Departmental advisory committees. Faculty members are asked to participate in Division planning activities to provide review and critique from an academic and practice perspective.

Although local health departments operate as autonomous entities, the state health agency funds a substantial amount of their services and the Division of Public Health works closely with them in all phases of program development, implementation and evaluation.

Strong relationships between state and local agencies are maintained by the continuous efforts of WCHS staff members to involve these agencies in the development, implementation and evaluation of WCHS initiatives. WCHS staff lead or participate in state-local collaborations that include, but are not limited to the following task force, on-going, or ad hoc working groups:
-Medicaid Outreach and Education
-Health Check Initiative
-Child Fatality Task Force
-Council on Developmental Disabilities
-IDEA Interagency Coordinating Council
-Smart Start Partnership for Children (Governor's early childhood initiative)
-Coalition for Healthy Youth
-Family Preservation/Family Support Initiative
-Healthy Child Care North Carolina
-Baby Love Program (enhanced services for pregnant women and infants)
-First Step Campaign (infant mortality reduction)
-Early Intervention Intra-agency Work Group
-WCHS/Medicaid Intra-agency Work Group

Adding to the success of these efforts is the strong involvement and participation of professional agencies in Division activities. The Division works closely with the medical societies (pediatric, obstetric/gynecologic, and family practice). The Division also maintains close working relationships with other advocacy and non-profit agencies that include the NC Partnership for Children, Prevent Child Abuse NC, and the NC March of Dimes.

The Community Care of North Carolina (CCNC) program is building community health networks organized and operated by community physicians, hospitals, health departments, and departments of social services. By establishing regional networks, the program is establishing the local systems that are needed to achieve long-term quality, cost, access and utilization objectives in the management of care for Medicaid recipients. The program office is based in Raleigh at the North Carolina Office of Rural Health and Community Care. The program office is sponsored by the Office of the Secretary, the Division of Medical Assistance, and the North Carolina Foundation

for Advanced Health Programs, Inc. Additional grant funding has been obtained for start-up and for pilot demonstrations from Kate B. Reynolds Health Care Trust, the Commonwealth Fund, and the Center for Healthcare Strategies. The North Carolina Foundation for Advanced Health Programs, Inc. is a private non-profit organization that also serves to provide staffing and grant funding opportunities.

In 2002, the NC DPH and the North Carolina Association of Local Health Directors undertook an initiative to develop a mandatory, standards-based system for accrediting local public health departments throughout the state. Since 2002, the North Carolina Institute for Public Health (NCIPH) has provided Accreditation staff support.

The focus of North Carolina's Local Health Department Accreditation (NCLHDA) is on the capacity of the local health department to perform at a prescribed, basic level of quality the three core functions of assessment, assurance, and policy development and the ten essential services as detailed in the National Public Health Performance Standards Program. The program focuses on a set of minimal standards that must be provided to ensure the protection of the health of the public, but does not limit the services or activities an agency may provide to address specific local needs. NCLHDA does not create a wholly new accountability system; rather it links basic standards to current state statutes and administrative code, and the many DPH and NC Division of Environmental Health (DEH) contractual and program monitoring requirements that are already in place.

The program comprises three functional components:
-An agency self assessment, which includes 41 benchmarks and 148 activities
-A three day site visit by a multidisciplinary team of peer volunteers, and
-Determination of accreditation status by the North Carolina Local Health Department Accreditation Board.

The program process is adjudicated by an independent entity, the North Carolina Local Health Department Accreditation Board. Its members are appointed by North Carolina's Department of Health and Human Services Secretary. The Accreditation Administrator within the NCIPH serves by legislative mandate.

Accreditation is achieved by appropriately meeting a set of capacity-based Benchmarks as evidenced by documented completion of prescribed Activities. Benchmarks may be met by either direct provision or assurance (through contracts, memoranda of understanding, or other arrangements with community providers) of required services and activities. While the Benchmarks being applied are similar to the Operational Definition of a Functional Local Public Health Agency by the National Association of County and City Health Officials (2004) and drawn from work done in other states, the Activities are specific to practices in North Carolina local public health agencies.

As of July 2009, 50 local health departments had been accredited. Due to budget cuts in FY10, the accreditation program was suspended for the FY10 period. It is hoped that accreditation activities will resume in July 2010.

F. Health Systems Capacity Indicators

Introduction

Data are available for all of the Health System Capacity Indicators through a variety of sources, but primarily through the State Center for Health Statistics (SCHS) from birth files, hospital discharge records, Medicaid records, linked/matched datasets, and various surveillance systems.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	61.5	62.7	26.0	26.3	25.2
Numerator	3554	3651	1534	1597	1568
Denominator	577894	582302	590582	607135	623069
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
In reporting CY08 (FY09) data, it was decided to change data to include only those hospital discharges with asthma as a primary condition, thus FY07 data forward are not comparably to data from prior years.

Notes - 2008
In reporting CY08 (FY09) data, it was decided to change data to include only those hospital discharges with asthma as a primary condition, thus FY07 data forward are not comparably to data from prior years.

Notes - 2007
In reporting CY08 (FY09) data, it was decided to change data to include only those hospital discharges with asthma as a primary condition, thus FY07 data forward are not comparably to data from prior years.

Narrative:
Data for this indicator have been revised to include only primary diagnosis codes instead of all diagnosis codes as had been included until now. This gives a more true picture of hospitalizations due to asthma for children under the age of five. Trend data shows a six percent decrease between 2005 and 2008.

Childhood asthma continues to be an important public health issue in NC. Data from the NC Child Health Assessment and Monitoring Program (CHAMP) survey show that in 2008, about 14.2% of children under the age of 18 in NC had been diagnosed with asthma at some point in their lives (lifetime asthma prevalence). This is more than a 20 percent decrease since the results of the first CHAMP survey in 2005, when 17.8% of children in North Carolina had asthma. In 2008, about 8.2% of these children still had this chronic condition (current asthma prevalence), a 28 percent decrease from the 2005 rate of 11.5%. The provisional US lifetime and current prevalence rates for 2008, which are the latest data available from the National Health Interview Survey, are 14% lifetime prevalence and 10% current prevalence. So, while the decreasing state rates are encouraging, North Carolina still has a higher prevalence that the nation. In North Carolina in 2008, in children less than 18, boys had slightly higher lifetime and current asthma prevalence rate than girls, and African American children had higher lifetime and current prevalence rates than their white counterparts, although these disparities in rates were smaller in 2008 than in 2007.

Asthma is the most common chronic disease in children and the leading cause of school absenteeism. In North Carolina, data reported through the North Carolina Annual School Health Services Report show a decline in the 2008-09 school year after two years of substantial increase in the number of students known to school nurses to have asthma.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	90.8	91.2	92.1	92.1	89.0
Numerator	95718	101575	107453	110720	107398
Denominator	105384	111411	116718	120255	120713
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
These data are taken from the HMLR5501 SFY report.

Notes - 2008
These data are taken from the HMLR5501 SFY report.

Notes - 2007
Prior to FY99, calendar year data are reported, but beginning with FY00, state fiscal year data (July-June) are reported. These data are taken from the HMLR5501 SFY report.

Narrative:
The percent of Medicaid enrollees whose age is less than one year who received at least one initial periodic screen has remained at about 90% for the past five years, although the rate decreased from 92.1% in both FY07 and FY08 and decreased to 89% in FY09. In January 2006, children age 0 to 5 in North Carolina whose family income is <200% of poverty became eligible for Medicaid. Thus, some infants previously covered by the North Carolina Health Choice for Children program (NC's State Child Health Insurance Program [SCHIP]) are now being covered by Medicaid. This policy change probably accounts for some of the increase in the denominator for this measure. The C&Y Branch staff members continue work on various outreach efforts to increase the number of children with health insurance and to emphasize the importance of having a medical home which also impact the percentage of infants receiving a periodic screen.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	74.3	71.8	92.1	92.1	89.0
Numerator	104	89	107453	110720	107398
Denominator	140	124	116718	120225	120713
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
As of January 1, 2006, children age 0 to 5 in North Carolina whose family income is <200% of poverty are eligible for Medicaid, so data on all infants is included in HSCI#02. The data placed in this field is just a repeat of HSC02 as an estimate was required.

Notes - 2008
As of January 1, 2006, children age 0 to 5 in North Carolina whose family income is <200% of poverty are eligible for Medicaid, so data on all infants is included in HSCI#02. The data placed in this field is just a repeat of HSC02 as an estimate was required.

Notes - 2007
As of January 1, 2006, children age 0 to 5 in North Carolina whose family income is <200% of poverty are eligible for Medicaid, so data on all infants is included in HSCI#02. The data placed in this field is just a repeat of HSC02 as an estimate was required.

Narrative:
The NC General Assembly in Senate Bill 622 under Section 10.22(a) changed the NC Health Choice for Children program to cover only children between the ages of 6 through 18 effective January 1, 2006. Children from birth through age 5 on NC Health Choice with income equal to or less than 200% Federal Poverty level are no longer eligible for NC Health Choice after January 1, 2006. These children have been moved to Expanded Medicaid with a new Classification Code of MIC-1. Please refer to HSCI 02 for information on these infants.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.8	86.7	85.6	85.3	85.6
Numerator	104833	106360	108935	111324	111535
Denominator	119378	122642	127265	130485	130358
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for previous CY (i.e., FY09 is really CY08).

Notes - 2008
Data are for previous CY (i.e., FY08 is really CY07).

Notes - 2007
Data are for previous CY (i.e., FY07 is really CY06).

Narrative:

Trend data for this indicator show that there has been a steady decrease over the past ten years from 88.9% for mothers of babies born in 1999 to only 85.6% to mothers in 2008, a three percent decrease. The WCHS continues to focus on enhancing the service provision of the state's Baby Love Program, with some enhancements being a new triaging system (risk factor screening process) and a new assessment and care planning process based on best-practice case management methods ("Pathways of Care for Maternity Care Coordination"). The intent of this new process was to focus resources and efforts on those individuals with the greatest need, and subsequently to accurately identify and effectively address those needs to improve the quality of MCC services. Making sure women are able to access prenatal care early and continually during their pregnancy remains a priority in the Baby Love program. Both the Healthy Start Baby Love Plus and the Healthy Beginnings programs continue to provide support services to pregnant women and encourage them to seek early and continuous prenatal care services. In addition, the First Step Campaign continues to promote the NC Family Health Resource Line (the MCH Hotline) and to increase public awareness about the importance of preconception health and prenatal care. Refer to the narrative for NPM#18 (Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester) for a description of activities undertaken to increase this percentage.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	87.8	88.3	88.6	89.4	90.2
Numerator	796361	854341	881005	922898	987039
Denominator	906853	968025	994403	1032444	1093866
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Notes - 2008
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Notes - 2007
The methodology for determining data for this measure changed starting with FY02 data. In years past, any claim was counted, but beginning with FY02 data, claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years.

Narrative:
The methodology for determining data for this measure changed beginning with FY02 data. In years past, any claim was counted, but now claims which did not include provider contact were eliminated, thus the percentage decreased quite a bit from previous years. Detailed explanation

of new methodology follows:

For Federal Fiscal 2009 (10/1/2008-09/30/2009) the number of children under age 21 XIX enrolled at some point with the year (for at least one day) was 1,093,866.

Under 21 receiving an XIX service, excluding those for which the ONLY claims were the system generated claims to pay the Carolina Access Fees or the Health Check Coordinator Prorated Salaries was 987,039. Under 21 HMO fees were INCLUDED.

Under 21s for whom a claim was paid whether an actual service or a system generated premium or fee was 1,077,134.

Since the change in methodology for determining data for this indicator occurred in FY02, the data for this indicator continue to increase, albeit slowly. The FY09 data show an almost five percent increase when compared to FY02 data (90.2% compared to 86.1%). Outreach efforts by C&Y Branch staff and LHD staff help maintain this percentage, as well as efforts to increase the number of children who have a medical home. The number of children eligible for Medicaid has increased by almost 37 percent during that same time period.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	37.9	39.9	42.1	43.8	43.7
Numerator	71513	83846	91877	100218	107245
Denominator	188464	210216	218377	228706	245217
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for previous CY (i.e., FY09 is really CY08).

Notes - 2008
Data are for previous CY (i.e., FY08 is really CY07).

Notes - 2007
Data are for previous CY (i.e., FY07 is really CY06).

Narrative:
The Division of Medical Assistance provides these data. In FY04, data from CY00 to CY02 were revised to include just those children receiving Medicaid and not those under the state SCHIP (Health Choice) plan. Thus, the data for FY99 and FY00 should not be compared to the rest of the data. The FY data are actually for the prior CY. There has been a 79 percent increase from 24.4% of children receiving dental care in FY01 to 43.7% in FY09.

In 1999, the NC Institute of Medicine (NCIOM) was asked by DHHS to convene a task force to evaluate and recommend strategies to increase dentist participation in the Medicaid program and

improve the preventive services provided by Medicaid. The NCIOM convened a one-day meeting in 2003 to review progress on these recommendations. At that time, twelve of the 23 original recommendations (52%) had been fully implemented and some action had been taken on 69% (116) of the recommendations. In April 2005, the Oral Health Section of DPH conducted the North Carolina Oral Health Summit: Building a Collaborative for Action. Participants at this one-day summit reviewed the findings and recommendations from the 1999 Task Force report to determine if the issues it addressed were still relevant, what actions had occurred to implement the Task Force's recommendations, and the barriers to implementation. The goal of the Summit was to identify potential strategies to improve dental care access - whether by further implementation of the original 1999 NC IOM Task Force recommendations - or through new strategies. Work continues to make dental services available in all parts of the state. A new dental school will open at East Carolina University in 2011. The Community Care of North Carolina program chose pediatric prevention, including dental care, as one of its clinical quality measures for 2009-2010.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	31303	32485	33702	34211	35056
Denominator	31303	32485	33702	34211	35056
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data Source: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Data are as of December 2009.

New methodology initiated in FY02 application and all indicators have been revised. Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Notes - 2008
Data Source: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Data are as of December 2008.

New methodology initiated in FY02 application and all indicators have been revised. Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Notes - 2007
Data Source: Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Data are as of December 2007.

New methodology initiated in FY02 application and all indicators have been revised. Since

January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina.

Narrative:
Since January 1, 1995, all SSI beneficiaries <16 years old have been eligible for Medicaid in North Carolina. In fact, North Carolina provides Medicaid coverage to all elderly, blind and disabled individuals receiving assistance under SSI. The NC child health insurance program (Health Choice) serves as an additional payment source for these children. The Title V program continues to assure that all SSI beneficiaries receive appropriate services. Each month, WCHS receives approximately 335 referrals of newly eligible SSI children. Those children under age five are referred to Early Intervention Child Service Coordination services, while the parents of those ages 5 and older are contacted by letter. The purpose of both contacts is to make families aware of the array of services offered under Medicaid, as well as other programs for which their child may qualify.

Among the 21,029 children reported to the C&Y Branch as eligible for SSI during the 2005 to 2009 assessment period, 13,249 (63%) were identified as having a Mental Disorder. Among those with a Mental Disorder, the most frequently reported primary diagnoses were Speech Language Delay (2,959/22%), ADHD (2,895/22%), Mental Retardation (2,333/18%), and Autism (1527/12%). Speech Language Delay is classified (by ICD-9 codes) as falling within the Mental Disorders category since most speech language disorders are related to a mental condition (such as autism and mental retardation). Among the 21,029 children receiving SSI benefits, 13,250 (63%) were reported as having a secondary diagnosis that also fell within the Mental Disorder category. The most frequently reported secondary diagnoses were: ADHD (2,239/17%), Speech Language Delay (1,582/12%), ODD (1,268/9%), and Learning Disorders (734/5%).

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	matching data files	10.5	7.6	9.1

Narrative:
Since 1985, North Carolina has linked Medicaid newborn hospitalization records to live birth certificates to identify which births were to families enrolled in Medicaid. After 1985, various other linkages have been added to promote data analyses related to maternal and child health. This birth file with added health services data is referred to as the North Carolina Composite Linked Birth File. It is also sometimes referred to as the "Baby Love" file, since much of it was developed initially for evaluations of the Medicaid expansions after 1987, collectively referred to as the Baby Love Program in North Carolina. Data that are now linked annually to the live birth file include: Medicaid newborn hospitalization records, Medicaid maternal delivery records, Medicaid maternity case management records, child service coordination records, prenatal WIC records, records of prenatal visits at public health clinics, infant death records, a summary of Medicaid newborn costs in the first 60 days of life, and a summary of Medicaid infant costs in the first year of life.

Data continue to remain almost constant for this indicator, with no major changes since 2001. For more information, see the narrative for Health Status Indicators #1A&B and #2A&B.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	10	6.4	8.9

Narrative:
As stated in HSCI05A, there North Carolina is fortunate to have a North Carolina Composite Linked Birth File from which data for this indicator are gathered. Data from calendar year 2007 are the most recent data for this indicator. In keeping with trend data for this indicator, there is a higher rate of infant deaths in the Medicaid population (10.0 per 1,000 live births) than in the non-Medicaid population (6.42). The rate of infant deaths in the Medicaid population has increased from 8.59 in 2000, while the rate in the non-Medicaid population decreased from 6.74.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	75.1	93	82

Notes - 2011
Data for this indicator differ from NPM#18 because this indicator is based on CY2008 data and NPM#18 FY2008 is really CY2007 data. This indicator matches the data listed under FY2009 in NPM#18.

Narrative:
As stated in HSCI05A, there North Carolina is fortunate to have a North Carolina Composite Linked Birth File from which data for this indicator are gathered. Data from calendar year 2008 are the most recent data for this indicator. Since 2001, data for this indicator have remained constant, with almost 75% of infants born to women receiving early prenatal care in the Medicaid population and about 93% in the non-Medicaid population. When the Medicaid group is broken down by type of Medicaid (Emergency Medicaid and All Other Medicaid), a disparity is shown as only 68.7% of women receiving Emergency Medicaid received prenatal care in the first trimester while 76.4% of women receiving other Medicaid had prenatal care in the first trimester. These data do show a slight increase from the percentages found in the 2007 data (64.2% in the

Emergency Medicaid group and 74.7% in the All Other Medicaid group). For more information regarding program activities aimed at improving this measure, see the narrative for NPM#18.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	82.6	88.8	85.5

Notes - 2011
Data for this indicator differ from HSCI#4 because this indicator includes women ages 18 through 50 and HSCI#4 only includes women ages 14 through 44. Also, this is CY08 data, so it would match up better with FY09 data for HSCI#4 which is actually CY08 data instead of FY08 data which is CY07.

Narrative:
As stated in HSCI05A, there North Carolina is fortunate to have a North Carolina Composite Linked Birth File from which data for this indicator are gathered. Data for calendar year 2008 show a slight decrease from 2001 in all three population groups for this indicator. Medicaid women with adequate prenatal care decreased from 84.5% in 2001 to 82.6% in 2008; non-Medicaid women decreased from 91.2% in 2001 to 88.8% in 2008; and the percentage of all women receiving adequate prenatal care decreased from 88.3% in 2001 to 85.5% in 2008. For more information regarding program activities aimed at improving this measure, see the narrative for NPM#18.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2009	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)		

Notes - 2011
As of January 1, 2006, children age 0 to 5 in NC whose family income is <200% of poverty are eligible for Medicaid.

Narrative:
These levels had stayed consistent since the state SCHIP program, Health Choice, began in 1998 and continued through 2005. However, the NC General Assembly in Senate Bill 622 under Section 10.22(a) changed the NC Health Choice for Children program to cover only children between the ages of 6 through 18 effective January 1, 2006. Children from birth through age 5 on NC Health Choice with income equal to or less than 200% Federal Poverty level are no longer eligible for NC Health Choice after January 1, 2006. These children have been moved to Expanded Medicaid with a new Classification Code of MIC-1. This change will be reflected in Form 18. There have been no changes to the Medicaid and SCHIP eligibility criteria since January 2006.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 18) (Age range to)	2009	 200 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 6 to 18) (Age range to) (Age range to)	2009	 200

Narrative:
These levels had stayed consistent since the state SCHIP program, Health Choice, began in 1998 and continued through 2005. However, the NC General Assembly in Senate Bill 622 under Section 10.22(a) changed the NC Health Choice for Children program to cover only children between the ages of 6 through 18 effective January 1, 2006. Children from birth through age 5 on NC Health Choice with income equal to or less than 200% Federal Poverty level are no longer eligible for NC Health Choice after January 1, 2006. These children have been moved to Expanded Medicaid with a new Classification Code of MIC-1. This change will be reflected in Form 18. There have been no changes to the Medicaid and SCHIP eligibility criteria since January 2006.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2009	185
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**

Pregnant Women		

Notes - 2011
The state SCHIP program, Health Choice, does not cover pregnant women.

Narrative:
In cooperation with staff DMA, the FPRHU is currently in the final year in the implementation of an 1115(a) a five-year demonstration waiver. The Medicaid waiver extends eligibility for family planning services to all women age 19-55 and men age 19-60, with incomes at or below 185% of the federal poverty level regardless of receipt of previous Medicaid reimbursed service (pregnancy-related or otherwise). The major goal of the waiver is to reduce unintended pregnancies and improve the well being of children and families in North Carolina. Among several objectives, two specifically target reductions in the number of inadequately spaced pregnancies and in the number of unintended and unwanted pregnancies among women eligible for Medicaid. The FPRHU and DMA are in the initial phase of re-applying for another five-year cycle of the FP Medicaid Waiver.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	**Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)**	**Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)**
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:
It is fortunate for the WCHS that the NC State Center for Health Statistics (SCHS) has a long history of linking data with infant birth certificates and creating the NC Composite Linked Birth File which was described in HSCI05A. Therefore, for the first three data linkages found in HSCI #09(A), the scored response for the first question is three, the state has the ability to obtain data for program planning or policy purposes in a timely manner. However, the WCHS has answered the question for the fourth linkage with one, meaning that the state does not have the ability to link birth certificates and newborn screening files. The Vital Records System Automation Project was started in 2000 but had its share of setbacks. In 2005, however, the state entered into a contract to purchase an upgrade to the existing Electronic Birth Certificate (EBC) system that moves the system to a web based application and implements the 2003 National Center for Health Statistics revised birth certificate. Roll out of this new system was initially scheduled to start in 2007, but this roll out has been moved back to 2010 or 2011. The State Laboratory of Public Health houses the newborn screening data in their Laboratory Information Management System (LIMS). There are no current plans to link the EBC system and LIMS or for one database to populate the other database. However, after both systems have been in place for a year or two, the SCHS has agreed to work with the State Systems Development Initiative (SSDI) Project Coordinator to attempt to match data files from each system. If successful, and given that it would not place an undue burden on vital records or public health laboratory staff, this match would then become an annual activity.

Staff from WCHS also collaborate closely with the SCHS on the surveys and registries mentioned; therefore the score attributed to these questions is also three. Hospital discharge data are available as needed. The Birth Defects Monitoring Program (BDMP), which is located in the SCHS, provides annual birth defects surveillance data. The SCHS first began collecting data through PRAMS on July 1997 births. Findings from the BDMP and PRAMS survey are distributed to LHDs, state agencies, state legislators, professional societies, and others, primarily via the SCHS website.

The second part of HSCI #09(A) asks whether the state's MCH program has direct access to the electronic database for analysis. Again, thanks to a long history of working with the staff of the SCHS, the answer to this question for all but the newborn screening data is yes. For the most part, requests for data are made by WCHS staff to statisticians at the SCHS who work with the databases and surveys, but should the need arise for a WCHS staff member to have direct access to the database, that could be arranged.

The role of the SSDI Project Coordinator position is to help increase the WCHS's capacity to utilize and analyze data and to improve data linkages.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes
Youth Tobacco Survey (every other year)	3	Yes

Notes - 2011

Narrative:
North Carolina participates in the Youth Risk Behavior Survey (YRBS) which provides information about tobacco use in teens every two years. The Tobacco Prevention and Control Branch

(TPCB) of DPH conducted the first NC Youth Tobacco Survey (YTS) in the fall of 1999. Since then TPCB has conducted six NC Youth Tobacco Surveys--every fall in odd numbered years. The 2009 NC YTS provides a critical source of public health data for understanding the scope of the tobacco problem and measuring progress toward overall goals among youth. The 2009 NC YTS is a comprehensive statewide representative sample of more than 7,100 middle and high school students. The 2009 YTS showed that 10.5% of middle school students reported use of some form of tobacco in the past month, down from 17.4% in 2001, close to a 40 percent decrease, but up from 9.1% reported in the 2007 YTS. Among high school students, 25.8% of high school students reported use of some form of tobacco in the past month, compared to 35.8% in 2001, an almost 28 percent decrease.

Per 2008 NC CHAMP Survey results, 65.9% of parents and caregivers of children 11 years and older that would like to learn more about teen issues would find it very helpful to learn about teens and tobacco.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Data collection and analysis for the majority of the National and State Performance measures are done collaboratively by staff within the WCHS and the State Center for Health Statistics. Specific information regarding most of these measures, including data sources and trends, can be found in the narrative portions for each measure and the detail sheet. Data from the 2005-06 National Survey of Children with Special Health Care Needs (NS-CSHCN) were pre-populated into the respective National Performance Measures. Due to changes in the survey questionnaire (substantial additions to questions, wording changes, ordering and placement of questions, and skip pattern changes), only data for National Performance Measures #2 (families are partners in decision making and satisfied with services that they receive) and #4 (adequate health insurance) are comparable to the outcomes found in the 2001 NS-CSHCN.

B. State Priorities

The WCHS conceives of priority-setting as a continuous process, in which useful data, both quantitative and qualitative, relevant to the broad mission of the section are continuously being gathered and analyzed with an eye to adjusting the priorities and the activities of the section as appropriate. In addition to these day-to-day "micro" analyses of relevant inputs, the section utilizes formal needs assessment processes, such as the five year MCHBG needs assessment process, to review and titrate section priorities and activities. In order to give a background context for the section's activities with respect to priority-setting in association with the MCHBG needs assessment process, some information about antecedent section priority-setting activities is provided.

During FY03, the SMT defined a consensus set of core WCH Indicators to be used to communicate the value of the work done by the WCHS with policymakers, stakeholders, and the general public. These indicators are the following:

1. Reduce infant mortality
2. Improve the health of women of childbearing age
3. Prevent child deaths
4. Eliminate vaccine-preventable diseases
5. Increase access to care for women, children, and families
6. Increase the number of newborns screened for genetic and hearing disorders and prevent birth defects
7. Improve the health of children with special needs
8. Improve healthy behaviors in women and children and among families
9. Promote healthy schools and students who are ready to learn
10. Provide timely and comprehensive early intervention services for children with special developmental needs and their families.

The purpose of defining the set of indicators was to be able to help the WCHS better define its mission and promote a common vision among staff. In addition, as these indicators are shared with stakeholders and policymakers, they provide information about how the work of the WCHS contributes to the welfare of the state. The process of defining the indicators also helped the SMT gain clarity about where evidence-based interventions exist and identify areas offering opportunities for improvement. Also, the choice of indicators helps Section staff understand core job responsibilities and evaluate performance as the indicators can be used in individual work plans. Another important outcome of the selection of indicators is that they allow for a more data-driven environment throughout the WCHS.

During the 2010 MCH needs assessment process, SMT members found that the broad priority areas previously identified provided an excellent template for describing to federal, state and local

stakeholders the charges given in North Carolina to the WCHS. While other states may use the needs assessment process to identify more narrow or more specific priorities, such as "improve school nurse to student ratio in public schools," or "increase the number of disorders screened by the newborn metabolic screening program," our approach, in which we aim to identify the full range of activities we are charged to support, seems to work well for us.

Because we are using such broad, inclusive categories, it has seemed reasonable to leave them unchanged--we feel no needs assessment process would ever lead us to conclude, for example, that "reducing infant mortality" or "improving the health of children with special needs" would not be a priority area for us. What the needs assessment has done, of course, is to provide us with a wide range of data that are allowing us to refine our strategies for reducing infant mortality, improving the health of children with special needs, and all of the other priority areas we have identified.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	230	242	220	257	219
Denominator	230	242	220	257	219
Data Source				NC State Laboratory of Public Health	NC State Laboratory of Public Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	100	100	100	100	100

Notes - 2009
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY08 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, Biotinidase Deficiency, Short Chain AcylCo-A Dehydrogenase (SCAD), GA-I, VLCAD, IVA, MSUD, IBDD, TFPD, and HPA.

Notes - 2008
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY07 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism,

Galactosemia, Sickle Cell Disease, MMA, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, Biotinidase Deficiency, Short Chain AcylCo-A Dehydrogenase (SCAD), CPT-II, PPA, IVA, GA-I, GA-II, 2-MBD, Tyrosinemia Type II, and Homocystinuria (HCY), VLCAD, LCHAD, MSUD, Citri-1, Met, IBD, CBL.A,B, and ASA.

Notes - 2007
Appropriate follow-up as defined by NC is provided to all newborns who are screened and confirmed with conditions mandated through the NC Metabolic Screening Program. These data are for CY06 and include testing for the following: Phenylketonuria, Congenital Hypothyroidism, Galactosemia, Sickle Cell Disease, MMA, Congenital Adrenal Hyperplasia (CAH), Medium Chain AcylCo-A Dehydrogenase (MCAD), 3-MCC, Biotinidase Deficiency, Short Chain AcylCo-A Dehydrogenase (SCAD), CPT-II, PPA, IVA, GA-I, GA-II, 2-MBD, Tyrosinemia Type II, and Homocystinuria (HCY).

a. Last Year's Accomplishments
The staff of the State Laboratory of Public Heath (SLPH) has completed the design of the Newborn Screening Laboratory and is working on the development of the new laboratory information system, STARLIMS.

Cystic Fibrosis (CF) newborn screening was implemented on April 13, 2009 and the newborn screening fee was raised to cover the cost. To comply with Clinical Laboratory Improvement Amendments (CLIA) regulations, the newborn screening laboratory participated in the CDC CF proficiency program. The supervisor of the hemoglobinopathies laboratory was selected to oversee the screening and two staff members were hired to perform the testing. A CF coordinator was hired and she completed the follow-up protocols for reporting abnormal CF results and linking appropriately with specialists. An education program was implemented that included a screening fact sheet and a slide presentation for use by physicians and parents. The newborn screening brochure was also updated to include CF screening.

The lab successfully passed the CLIA inspection in July 2009. The CF Lab supervisor participated in the Association of Public Health Laboratories (APHL) sponsored CF workshop in August 2008.

The new tandem mass spectrometry (MS/MS) rules were evaluated in terms of false positives, false negatives, and positive predictive value. A change in the funding sources was implemented to allow Medicaid funds to be used for medical foods for patients identified through the MS/MS newborn screening program. A series of information sheets was designed to fax to the primary care providers when a newborn in their care has an out-of-range value on their MS/MS newborn screen.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Initial newborn screening test performed on all blood spot samples received.			X	
2. Follow-up of borderline results with a letter to physician.			X	
3. Follow-up of abnormal results with a phone call to physician.			X	
4. Testing of repeat blood spots received following a borderline or abnormal screen.			X	
5. Continued interaction of state lab and medical center staff as relates to questionable results.				X
6. Contracts providing statewide coverage for consultation related to metabolic conditions.				X

7. Work towards development of data linkage of birth certificates and newborn screening records.				X
8. Purchase of special formula for individuals with certain metabolic disorders through Nutrition Services.		X		
9. Monitoring of phenylalanine, tyrosine, and phe/tyr ratios in blood spots received from individuals with PKU in routine medical management.			X	
10. Newborn screening advisory committee quarterly meetings.				X

b. Current Activities

The construction of a 220,000 square foot facility to house the SLPH and the Office of the Chief Medical Examiner (OCME) began in April 2010. The new facility will replace the 37-year-old building where the SLPH is currently located. The newborn screening laboratory continues to develop STARLIMS data system. A Laboratory Improvement Consultant was hired. In February. The SLPH Newborn Screening Dried Blood Spot Sample Usage, Storage, and Release Policy was approved, reducing the storage of residual blood spot specimens from indefinitely to 5 years. The state lab is recruiting new members to the Newborn Screening Advisory Committee.

The position for the health educator remains frozen, but the CF follow-up position was filled.

A new antibody for congenital adrenal hyperplasia (CAH) may reduce the number of false positive results. In 2009 there were 228 abnormal CAH screens and 6 diagnosed CAH. Of 1028 out-of-range MS/MS samples, the majority were from infants on Total Parenteral Nutrition medications that confound the results, and 33 infants received a diagnosis of an inborn error of metabolism. Statistical analysis of normal screens, true positive patients, and data accumulated by the Genetic Region 4 MS/MS project has led to the alteration of several cutoff values with the goal of eliminating false negatives. A total of 394 infants had abnormal CF screen results, leading to 22 diagnoses of CF and seven diagnoses of CF transmembrane conductance regulator metabolic syndrome.

c. Plan for the Coming Year

The SLPH will start a discussion with members of the North Carolina Newborn Screening Advisory Committee about the possibilities of adding lysosomal storage disorders (LSD) and severe combined immunodeficiency syndrome (SCID) to the screening panel in NC. The laboratory staff will collaborate with Duke University and Advanced Liquid Logic to develop the methodologies for LSD and SCID. Evaluation of very low birth-weight babies to determine if the LSD enzyme activities are detectable at the newborn period is also planned.

An ongoing project between Dr. Beth Tarini (Michigan) and Dr. Dianne Frazier (North Carolina) is comparing physician and consumer experience with receiving positive MS/MS newborn screening results. The first phase, designing and implementing a survey to see how follow-up is done for positive MS/MS newborn screening results throughout the United States, is nearly complete. The second phase will seek to compare patient and physician experiences from a well-established NBS program (NC) with one which has only recently added MS/MS to their newborn screening platform (MI).

The follow-up staff and consulting pulmonologists have developed a tool to evaluate the success of the CF screening and follow-up program and materials over the course of the next year. The CAH antibody change will be evaluated over the upcoming year.

The genetic and metabolic contracts were not a part of the ten million dollar 2009/2010reductions for the Branch. Additional reductions are anticipated during the 2010/2011 fiscal year which may reduce funding to support genetic services.

Completion of the new laboratory facility is anticipated in February 2012.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	**130403**					
Reporting Year:	**2008**					
Type of Screening Tests:	**(A) Receiving at least one Screen (1)**		**(B) No. of Presumptive Positive Screens**	**(C) No. Confirmed Cases (2)**	**(D) Needing Treatment that Received Treatment (3)**	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	130403	100.0	4	4	4	100.0
Congenital Hypothyroidism (Classical)	130403	100.0	183	57	57	100.0
Galactosemia (Classical)	130403	100.0	17	9	9	100.0
Sickle Cell Disease	130403	100.0	114	114	114	100.0
Biotinidase Deficiency	130403	100.0	3	1	1	100.0
Other	130403	100.0	18	18	18	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	130403	100.0	214	5	5	100.0
Medium-Chain Acyl-CoA Dehydrogenase Deficiency	130403	100.0	10	10	10	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75
Annual Indicator	65.3	65.3	58.3	58.3	58.3
Numerator					

Denominator					
Data Source				2005-06 CSHCN SLAITS Survey.	2005-06 CSHCN SLAITS Survey.
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	75

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The Family Liaison Specialist (FLS) and Family Council (FC) advised, planned, and promoted increased family-professional partnerships with community and public health partners. Strategies to expand Council member participation at state, local and regional levels were developed, including:
-Assuring a liaison role for FC council members between parents in local communities and the C&Y Branch staff/collaborative partners;
-A community education workshop on Title V;
-Training content for family professional partnership co-training;
-Expansion of family leadership skills training; and
-Ongoing planning for the MCH Needs Assessment specific to Children and Youth with Special Health Care Needs (CYSHCN).

A Family Council member, presented at the 2009 Association of Maternal and Child Health Programs (AMCHP) conference on behalf of the C&Y Branch program in newborn hearing screening.

The Council worked with the NC Commission on Indian Affairs to assure increased membership from the American Indian population. New members selected to the Council included fathers, grandparents, parents whose children received Early Intervention (EI) services, families from the farthest geographic areas of the state, and a second tribal representative.

Our staff continue to universally use family and provider satisfaction surveys to obtain feedback on services provided to families and professionals in NC.

Pairs of families and professionals were identified to jointly plan for increased family professional

partnerships across the C&Y Branch. These partners collected baseline information on Branch activities in transition, school health, and workforce development. Joint planning was continued for compilation of the Five Year Needs Assessment and for the Innovative Approaches (IA) grants, community collaborative grants to improve systems of care for CYSHCN so that families are satisfied with the care their children receive and services are coordinated and readily accessible.

Three parents of CYSHCN from the Council worked with UNC Chapel Hill leadership program to develop training scenarios, finalize a curriculum, and co-facilitate the Cultural Competence/Family Professional Partnership (FPP) workshop for the UNC LEND program. The FLS is a member of the MCH Leadership Training faculty, and a member of the planning committee for the national Maternal and Child Health Public Health Leadership Institute (MCHPLI).

An important component in assuring access and involving families has been sharing health care information. Our CYSHCN Help Line has been a key resource for families and providers in obtaining information on public programs that serve CYSCHN. For FY09, the percentage of calls asking for information about CYSHCN was 82%. At least 25% of the calls required follow-up to address a caller's questions/issues. The SCHIP outreach personnel provided information about SCHIP to a local parent support group with NC Autism Society. A presentation on strategies for providing services to CYSHCN was shared at the Farmworker Institute Summit, a one-day summit of statewide advocates that serve the migrant community. The NC Migrant & Seasonal/Regional Head Start Collaboration Task Force developed questionnaires for centers across the state looking at services utilized and gaps in services for migrant families.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. With the support of the Family Liaison Specialist, involvement of families of CYSHCN in the Family Council and on program, planning and evaluation committees of WCHS and systems of care partners.				X
2. Toll-free Help Line continues to provide information and support for families of CYSHCN.		X		
3. Parent members continue to work with the NC Commission on Children with Special Health Care Needs, the UNC MCH Leadership Training Program, newborn hearing and metabolic programs, and receive standing invitations to Branch meetings.				X
4. At least two representatives from the Family Council attend AMCHP conferences.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current activities include:
-Updating procedures for family involvement.
-Developing CYSHCN Help Line satisfaction survey.
-Developing evaluation for FC activities.
-Evaluating member mentoring program for FC.
-Management team met with FC to outline partnership plans.
-Increasing co presentations by families and Branch staff.

Family members participate in:
-Linking Actions for Unmet Needs in Children's Health (LAUNCH) advisory groups:
-DMA case management redesign teams;
-UNC's MCH Leadership design group;
-Governor's Commission for CSHCN;
-Behavioral Health Planning Group;
-Oral Health Committee;
-Early Hearing Detection and Intervention (EHDI) Advisory Group;
-IA community teams; and
-School Health Center Alliance.

FC members are signing up for joint work with Branch staff. A family member was recommended for the Governor's Early Childhood Council. A partnership curriculum for competencies will be available to families and professionals through web-based and on-site training;

Funding description presented to the FC and Commission for CSHCN to jointly determine $10 million reduction recommendations.

Family and provider satisfaction surveys used as feedback to improve QA.

The DMA focused on a redesign of case management services. The goal is to reduce cost and duplication by developing one system of case management. This has major implications for service coordination. Families have been closely involved in these meetings. The Branch Head chaired the Service Definition committee.

c. Plan for the Coming Year
Activities for FY11 include:
-Diversity of Council membership and outreach messages will remain a priority.
-Units will utilize budget allocations to increase involvement with family members in planning, implementing, and evaluating services.
-Members of the FC will investigate increasing social networking as a communication platform.
-Evaluation of FC efforts will remain a focus for the coming years.
-The skills based leadership curriculum will be piloted with external partners and in differing formats.
-The FC mentoring program will continue to be improved as evaluations produce feedback.
-The partnership with UNC MCH Leadership Training programs will continue. Families and the FSL are leadership fellows and co-trainers
-The LAUNCH project for system improvement in Guilford County will include family members on both the local and State advisory councils.
-The four Innovative Approaches grants for community wide systems improvement for CSHCN will improve family participation in planning.
-A series of trainings for Branch staff and key partners, including parents, is planned to focus on early and adolescent brain development, systems building strategies, child maltreatment prevention, autism, and traumatic stressors for children and families.
-The Newborn Metabolic Screening committee, led by the State Laboratory will be encouraged to include several family members. C&Y Branch will provide the needed financial support.
-Co presentations of Branch staff and family representatives will increase.
-The State Strategic Plan for Family Involvement will be completed and implemented.
-Families will participate in the training series outlined in current year activities section.

The Branch plans to redesign work flow across our service system by using a developmental trajectory model focusing on early childhood, pre adolescent and adolescent service systems. Family members will be closely involved with this work. Priorities for services will be reconsidered in light of the significant budget reductions. An increased focus will be on systems

improvement.

Our Family Health Resource Line was lost through budget reductions resulting in a significant expansion to the toll-free help line for CYSHCN. The results of the CYSCHN Help Line Customer Satisfaction Survey will be used to assure quality in service delivery.

In shifting funds we have increased the Family contract reimbursement by $30,000. In addition to usual costs for family participation, $6000 has been allocated to each Unit management team to improve family participation in their programs.

The Branch will continue to support the contracts for evidence based parenting programs in fifteen counties.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	75	75	75	75	75
Annual Indicator	55.6	55.6	46.5	46.5	46.5
Numerator					
Denominator					
Data Source				2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	75	75	75	75	75

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments

Activities conducted in FY09 included:

-Branch staff created and distributed surveys to assess the importance of medical home for families and providers and to evaluate education materials.

-A statewide listserv was implemented to improve planning discussions and share information related to state and national medical home data efforts and opportunities.

-The DMA held a series of meetings to obtain input from a variety of providers to differentiate definitions of care and case management. The DMA identified CCNC of NC as the one agency to provide care management (population based disease management). Methods were explored to focus both types of management on improving medical home services. A major target was to identify ways to utilize the data system from CCNC to improve coordinated case and care management for families. Families were involved in these meetings and discussions.

-CCNC is the primary system for medical home development in NC. It is focused primarily on Medicaid enrolled children, but the assumption is that changes in provider service delivery will positively impact all children. This statewide group was legislatively mandated to assume responsibility for care management of the Blind, Aged and Disabled population and reimbursement for managing children in SCHIP (Health Choice) was discontinued until CCNC groups could provide evidence of follow up for these children. Obviously, this was a year of changes that added challenges to medical home operation in the area of coordinated care.

-CSC funds allocated to LHDs for case management of non-Medicaid children had not been fully utilized for several years. These funds were redirected to fund four IA grants at $250,000 each for three to five years at the local level. The purpose of the grants is to improve systems of care for CSHCN in each county and, in some cases, multi counties. Receipt of these grants required proven ability to plan and coordinate effectively among private providers, health departments and families. The ultimate purpose of these grants is focused on improving medical home service delivery and effectively involving all agencies in the county in planning effective system change.

-An environmental scan for NC Title V and state efforts related to medical homes was conducted at the request of a consultant working on an MCHB funded regional training in New England.

-Early childhood indicators were developed through a grant from the Maternal and Child Health Bureau (MCHB). Staff use these indicators as a way to encourage early childhood partners to question if a child has a medical home on intake forms and in every encounter.

-Staff reviewed intake processes used in local health departments statewide and other state supported clinics to assure that a medical home question is used and processes are present to link children with a medical home when needed.

-The "Make Each Doctor's Visit Work For You" bookmark was updated which complements the "Choosing a Quality Medical Home" bookmark.

-The DVD on monitoring hearing loss in a medical home continued to be promoted and strategically distributed to partners across the state.

-EHDI staff participated in a National Initiative for Children's Healthcare Quality (NICHQ) newborn hearing collaborative to improve measures for screening, evaluation and referrals.

-The Carolina Health and Transition (CHAT) project held a statewide conference for national and state partners focusing on medical homes. The CHAT project piloted its training and advocacy materials statewide with youth, families, and medical providers and collected evaluation data.

-The Branch worked with Emergency Medical Services for Children (EMS-C) and the CHAT project to promote the use of a portable emergency medical summary for CYSHCN by the medical home.

-A medical home demonstration project, The Partnership for Health Management (P4HM), funded by the Branch developed a medical home tool box now being used by CCNC networks, the NC Pediatric Society (NCPS), and LHDs. P4HM will provide training and technical assistance to interested practices across the state.

-The NCPS led a grant funded Foster Care Medical Home Collaborative. Funding was used to develop a strategic plan for NC and SC.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate the families of children enrolled in HC and NCHC, other community agencies, and other providers on the importance of a medical home.				X
2. Support systems of care that assure children are screened early and often for special health care needs.				X
3. Maintain a toll free Help Line for referral of CSHCN to appropriate programs, services and providers.		X		
4. Participate in discussions and presentations related to the patient centered medical home with primary care providers and their state professional organizations.				X
5. Widely disseminate educational information and materials developed specifically for increasing medical home awareness with parents of CSHCN.			X	
6. Support systems of care that assure CSHCN have access to and are linked with a medical home.				X
7. Support transition as part of care provided in the medical home in the form of self-management of chronic disease and planned transfer to adult health care.			X	
8. Use, analyze, and promote data on CSHCN to inform efforts related to the promotion of the importance of a medical home.				X
9. Support and promote the development of family-professional partnerships.			X	
10.				

b. Current Activities

In FY10, the following activities occurred:

-The evaluation of IA grants to support community strategies for systems of care (SOC) is based on the six national CSHCN performance measures. A UNCG contract was awarded to train counties on community development strategies, and develop logic models for system change and action plans. A multi agency group including, churches, families, data system specialists, early childhood specialists, adolescent specialists, schools, child care, philanthropic groups, insurance agencies, hospitals, medical specialty groups, civic organizations, and others are working as a team for change improvement.

-The Early Childhood grant brought together key partners to improve SOCs. It has segued into a Governor's Council for Early Childhood. A $3,000,000 grant supports this effort.

-Work continues on a transition toolkit and web-based course. A DVD, "Views of a Medical Home," was completed that promotes medical home and transition strategies.

-Negotiations have been initiated with CCNC to partner in community grant implementation to enhance SOCs for CSHCN in collaboration with medical homes.

-Revised EPSDT policy for adolescent screenings with DMA and community providers. Revisions are based on Bright Futures recommendations. DMA is supportive of implementation, but budget shortfalls have delayed State approval.

c. Plan for the Coming Year

The Branch will continue activities to:

-Analyze state and national data related to CSHCN and the use of a medical home to help with outreach and awareness;

-Promote and share the materials and web site developed jointly with CCNC and the NC Healthy Start Foundation (NCHSF)

-Use the CSHCN Help Line as a statewide resource for HC and NCHC clients, families and providers;

-Promote evidence-informed screening, treatment, and follow up within a quality medical home

with providers and families in public and private settings;
-Work with state agencies to determine the best ways to help providers, families, and youth to address transition to adult health care within the context of a medical home; and
-Work with the NCPS, NC Academy of Family Physicians (NCAFP), CCNC and Area Health Education Centers (AHECs) to increase the number of primary care practices that work toward recognition as patient centered medical homes.
-Enhance the EHDI program with a focus on re-screening and follow up of abnormal screening results in the medical home, using the lessons learned from the NICHQ project in working with two large nurseries about identifying a medical home for newborns prior to discharge.
-Work with CCNC and DMA on the Children's Health Insurance Program Reauthorization Act (CHIPRA) quality demonstration grant. The proposed grant activities include: implementation and evaluation of the new set of quality measures from CMS/AHRQ; testing and evaluating provider-led community based medical home pilots within several CCNC networks to identify, treat, and coordinate the care of CSHCN, particularly children with developmental/behavioral and/or mental health disorders; and implementation of a model electronic health record for children.
-Promote Statewide Health Information Exchange and Health Information Technology efforts to enhance the abilities of primary care practices to serve as medical homes, especially in small, rural communities.
-Provide technical assistance and support with contracted staff from UNC Greensboro to the four counties receiving the Innovative Approaches grants. Grantees will identify promising practices related to the five national performance measures for CSHCN and disseminate these practices to other communities. Viable replication plans are part of the deliverables for the UNCG contract.
-Work with LHDs to keep them current on state and national guidelines and strategies about risk assessments, screenings, and anticipatory guidance as appropriate through agreement addenda requirements, web based trainings, and technical assistance. About half of LHDs serve as medical homes for CSHCN.
-Work from the Foster Care Medical Home Collaborative will continue. An advisory group is being proposed to work on some components of the strategic plan related to DSS and CCNC activities.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	80	80	80	80
Annual Indicator	57.3	57.3	63.7	63.7	63.7
Numerator					
Denominator					
Data Source				2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	80	80	80	80	80

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
The C&Y Branch continued to work with DMA and the State Health Plan (SHP) to ensure prompt claims processing during the NCHC transition to a new claims processing system. DMA staff were included in Commission on CSHCN meetings and provided regular updates on activities. Branch staff, which have lead responsibility for Health Choice outreach and CSHCN, focused on ensuring that services for NCHC CSHCN are equivalent to those services that are regularly provided to CSHCN under Medicaid. The Health Choice Benefits Handbook was updated and is posted online in English and Spanish.

The Commission on CSHCN, staffed by the Branch, finalized its strategic plan. A new priority was to increase access to oral health services. The Commission, in partnership with the NC Office on Disability and Health (NCODH) and the FC, assumed oversight of a multi-agency Oral Health Work Group to address this issue The Commission also shared concerns and recommendations regarding several behavioral health service definitions with the Governor, DHHS Secretary, and DMA/DMH leadership. They continued to monitor claims-paid data on high-cost, high-use behavioral health services for NCHC enrollees. Branch staff joined the DMA/DMH Behavioral Health Definition Workgroup to ensure that Commission members' recommendations regarding behavioral health services for CSHCN were carefully considered.

The CSHS Program, supported by the Branch and administered through Purchase of Medical Care Services (POMCS), was closed and transferred to DMA. The vast majority of services approved through this program are now being covered under the expanded definition for EDSDT administered by DMA. The funding that supported CSHS was used to support NFP programs, Innovative Approaches grants and evidenced based parenting programs.

As a result of reinterpretation of coverage under the EPSDT program, the Branch negotiated with DMA to include coverage for oral formulas which greatly assists newborns with metabolic disorders.

A ten year data report on information shared by 20,000 CSHCN Help Line callers was developed. The report focuses on the barriers families experience in accessing affordable health insurance for CSHCN.

The EHDI Initial Hearing Aid Program funds were reduced and later reinstated. This resulted in a period of time with no reimbursement for first time hearing aids for babies. The EHDI Advisory Committee's advocacy was instrumental in reversing the reduction decision during FY 2009/2010.

The Sickle Cell Syndrome Program in WCHS continued to provide services related to the treatment of sickle cell disease to financially eligible children.

The Pediatric Medical Consultant (PMC) participated in Physician Advisory Group (PAG) meetings to develop and/or review clinical policies for DMA on a number of services for CSHCN enrolled in Medicaid.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain Health Check/NC Health Choice (HC/NCHC) Outreach Campaign in coordination with the NC Healthy Start Foundation, DMA, State Employees Health Plan and DMH/DD/SAS.			X	
2. Maintain NC Family Health Resource Line as a bilingual informational telephone hotline.			X	
3. Continue to expand HC/NCHC Outreach web site.			X	
4. Continue to expand HC/NCHC educational campaign regarding medical home/ER use/preventive care.			X	
5. Simplify enrollment/re-enrollment forms and develop/disseminate family-friendly notices.		X		
6. Develop comparable data sets for HC and NCHC.				X
7. Target outreach to special populations (including minority and CSHCN).			X	
8.				
9.				
10.				

b. Current Activities

Some of the activities occurring in FY10 included:

-The Commission for CSHCN monitors legislation that impacts the special needs population and makes recommendations to DMA, the Governor, and other key players. The Commission has made oral health a priority and meets with the legislatively mandated Special Care Dentistry Advisory Group, which has submitted a recommendation to the General Assembly to add a dentist to the Commission.

-Staff target outreach to CSHCN to assure that uninsured/underinsured children are enrolled in the State's insurance programs and access quality medical homes. The Branch financially and administratively supports school-based and school-linked health centers in 17 counties.

-The numbers of CSHCN enrolled in SSI/Medicaid are monitored monthly with contacts to families about available services.

-Through advocacy by Beginnings, legislation was passed to mandate coverage of hearing aids by insurance companies. Legislative advocacy has occurred for the last three years, so it is quite an accomplishment for individuals with hearing loss.

-Implementation of coordinated activities with the Pediatric Society are occurring to use the Kindergarten Health Assessment (KHA) in 16 counties to increase identification of children qualified, but not yet enrolled, in Medicaid or NCHC.

-School nurses, in counties identified as participants in a statewide random sample of KHA information, provided data to the Branch to be used as baseline information.

c. Plan for the Coming Year

Plans for FY11 include:

-DMA, SHP and C&Y staff will ensure that services for CSCHN continue to be met while transferring NCHC medical policies from the SHP format into the DMA format. The new Medicaid Management Information System will begin processing Medicaid and NCHC claims in 2011.

-Branch staff will continue to be involved in the PAG process related to the development, elimination, and/or review of clinical policies and services for Medicaid CSHCN and now for

NCHC CSHCN.
-The Commission's Oral Health Workgroup will continue to partner with the Special Care Dentistry Advisory Group, the FC, and ODH to promote access to oral health care for CSHCN.
-The Commission will collaborate with Inclusive Health Care's High Risk Insurance Program to promote the availability of this insurance for CSHCN who do not qualify for Medicaid or NCHC, do not have access to group coverage, and would otherwise be unable to afford private insurance due to pre-existing conditions.
-Commission members and staff will participate in DMA Behavioral Health Definition Workgroups to revise and strengthen current behavioral health services for CSHCN. This group will monitor claims paid data for behavioral health services to determine changes in utilization trends. Staff will collaborate with DMA to develop a three-year contract with a behavioral health utilization review vendor for Medicaid and NCHC CHSCN. The vendor will participate in Commission workgroups and meetings.
-Staff will monitor CSHCN enrolled in SSI/Medicaid monthly and contact their families to make sure that they can access Medicaid available services. The CSHCN Help Line staff will provide information to families and health care providers of CSHCN on available insurance programs. The Help Line Report will be condensed and disseminated to a wider audience. It will be used to assess trends in service needs and inform discussions about adequacy of service coverage for CSHCN.
-Minority outreach to families of CSHCN will be provided through a staff member of Hispanic background who successfully focuses on populations that are hard to reach through key contacts in the communities representing Hispanic, American Indian, African American, Asian and Hmong.
-The Branch will provide support to school-based and school-linked health centers that focus on provision of comprehensive medical services to adolescents. Services are billed to Medicaid or private insurances, but not to families.
-The LAUNCH and IA grants will focus on increasing community capacity to serve young children and children with special health care needs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	80.6	80.6	89.3	89.3	89.3
Numerator					
Denominator					
Data Source				2005-06 CSHCN SLAITS Survey	2005-06 CSHCN SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	90

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
FY09 activities by C&Y Branch staff to improve community-based service systems included:
-Case management staff vacancies at the local level often were not filled due to the concern about DMA redesign of the service. Vacancies increased with growing concern about the security of jobs which impacted availability of coordination for families.
-Capacity assessments for the LAUNCH grant were used to assess community and state gaps in services.
-The Genetics/Metabolic program staff worked with pulmonologists and hospital partners to increase cystic fibrosis follow up services for newborns.
-Approximately one quarter of Branch positions were frozen by the State in anticipation of budget reductions. This significantly impacted our ability to work effectively with communities.
-Strengthened partnerships among the Child Service Coordination Program (CSCP), EI Branch, and Local Education Authorities (LEAs) in providing transition services by CSCP and EI staff jointly; surveyed local providers regarding successes and challenges of partnership; developed and presented training for state health directors and local providers based on survey results; facilitated local provider meetings to strengthen partnership.
-Training for case coordinators included: Involving Families in Service Provision (parent co-presenter); Family Partnerships and Empowerment (parent presenter); and Understanding the Impact of the Economic Crisis on Families (parent co-presenter).
-Monitored, collected and compiled monthly data related to newly enrolled SSI recipients. Recipients under age five were referred to the CSCP for potential enrollment in the EI or CSC Programs. Families of recipients five and older were contacted by letter to offer assistance in understanding benefits and accessing services under Medicaid. Information on other public programs for which SSI recipients may qualify was provided.
-Assistive Technology Resource Centers (ATRCs) conducted community needs assessments, created new display boards, translated the ATRC brochure into Spanish, and administered a Customer Satisfaction Survey.
-Expanded trainings to increase the number, skills, and distribution of local physical therapists (PT). A Family Satisfaction Survey was used during onsite PT consultations.
-Completed an assessment and plan to increase services for CSHCN in child care settings.
-Promoted use of KHA data to enhance communication among families, LEAs, and providers to meet the needs of CSHCN in school settings.
-Encouraged LHDs to hire behavioral health specialists to be out-stationed in private practices. Grantors supported 59 co-location projects with private and public providers and developed a plan for ongoing funding.
-Discontinued funding for the pilot child care center for medically fragile children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue Child Service Coordination Program.		X		
2. Continue provision of Early Intervention services and implementation of system design changes.	X			
3. Continue CSHS Clinics.	X			
4. Continue Special Needs Helpline.		X		
5. Continue child care for children who are medically fragile.	X			
6. Continue to advocate for additional school nurses and provide education and training to enhance their intervention skills in work with CSHCN.				X
7. Develop infrastructure to support transition services.				X
8. Continue statewide network of seven Assistive Technology Resource Centers	X			
9. Continue consultation, TA, and training for community PT and OT providers.				X
10.				

b. Current Activities

FY10 activities by C&Y Branch staff to improve community-based service systems included:
-PT consultants worked with Division of Vocational Rehabilitation to transfer equipment and services to their administration.
-The NCIOM convened an Adolescent Task Force to review current services and recommend improvement strategies, one for a Center for Adolescent Health in our Branch.
-Developing both local and State early childhood strategic plans to meet deliverables for the LAUNCH grant.
-Training two cohorts of new child care health consultants.
-Issuing a Request for Application (RFA) for school health centers. Some funding was shifted from existing to new centers. A Kate B. Reynolds grant was obtained to offer centers a year of transition funding.

There were program reductions or eliminations in the following areas:

School health centers
Community care coordinators
Hemophilia
Adult Cystic Fibrosis
Assistive Technology Resource Centers
Community Transition Contracts
CSHS Purchase of Care program
Transition
Major losses and redirection of case management services
Family Resource Hotline Contract and Child Care Health and Resource Line
Expanded Role Nurse Training
Training contract supporting Child Health, School Nursing, CFPT and EHDI conference

The following positions were lost:
Operations Unit Manager
Lead PT position
Social Work position for CSHCN
Data specialist/School Health
Nutrition position for CSHCN
Two secretary positions
Specialized Services Unit Manager

Speech Pathologist
Genetics Social

c. Plan for the Coming Year
Activities planned for FY11 include:
-An environmental scan to determine current capacity for early childhood services was completed in Guilford county and at the State level. Systems change will focus on identified community and State gaps in services and systems operations.
-A newly designed case management system will be implemented for all services. Final decisions on the approved model and case rates are still pending.
-Administrative rules and pathways of care will be created for the case management model. MCC and CSC will be combined into a Family Case Management service.
-Staff are working with NC Partnership for Children to expand the Assuring Better Child Health and Development (ABCD) program which is an intervention in primary care physician offices designed to assure that all children receive appropriate developmental screenings and referrals.
-Continued membership in the Alliance for Evidence-Based Family Strengthening Programs, a collaborative effort of public and private funders in NC to jointly fund and provide scaffolding support to select evidence based programs for children and families.
-Expand linkages to the counties funded for Innovative Approaches. Develop, through the assistance of UNCG, a viable plan for replication.
-Continue work on LAUNCH grant, funded by the Substance Abuse and Mental Health Services Administration (SAMSHA), in Guilford County and at the state level to expand use of evidence-based practices, improve collaboration among child-serving agencies, and integrate physical and mental health services for children ages 0 to 8.
-Participate in NC Health Information Technology efforts to support the development of electronic health records and information exchange among hospitals, primary care providers, health departments, and other public health and DHHS programs.
-Work with the CHIPRA Quality Measures grant awarded to CCNC to pilot care coordination for CSHCN and a pediatric electronic health record.
-About half of the health departments and community health centers in the State have developed dental clinics that serve low income children
-Continue to work with and expand the school nurse case management program for students with chronic health conditions.
-Continue to work with child care health consultants to help child care providers understand and help parents access community based services for CSHCN in their facilities.
-Implementation of the Governor's Early Childhood Advisory Council will occur during the upcoming fiscal year. The Governor has charged the Council with moving toward an effective, coordinated and efficient system of services for young children and their families out of the current multiple systems for early care and education, family strengthening and health.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5.8	5.8	5.8	45	45
Annual Indicator	5.8	5.8	39.9	39.9	39.9
Numerator					
Denominator					
Data Source				2005-06 CSHCN	2005-06 CSHCN

				SLAITS Survey	SLAITS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	45	50	50	50	50

Notes - 2009
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

Notes - 2008
The data reported in 2008 are pre-populated with the data from 2007 for this performance measure as there are no additional state data sources for this measure. This data point is not comparable to the results of the 2001 CSHCN SLAITS Survey.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
Activities occurring in FY09 included:
-The CHAT project held the first NC Transition Conference in Fall 2008. A DVD, "Views of a Medical Home" was developed which promotes the use of medical home and transition strategies with families. Branch staff shared transition best practices and resources as part of the strategic planning process for NC Foster Care Medical Home Collaborative lead by the NCPS.
The NCIOM Adolescent Health Task Force recommendations included transition related recommendations for all adolescents and especially YSHCN. NCIOM Task Force on Transition for People with Developmental Disabilities included recommendations addressing transition issues across the lifespan.
-CHAMP survey provided data related to transition, and questions related to transition were added to the 2010 survey. The Alliance of Disability Advocates, Exceptional Children's Assistance Center, and Mountain Area Health Education Center (MAHEC) conducted workshops for families, youth and medical providers to increase awareness about health care transition into adulthood.
-The Youth in Transition Collaborative addressed issues related to transition for public health, mental health, and foster care youth who are transitioning to adulthood and leaving the foster care system. The C&Y Branch conducted a survey of medical providers which included questions about perceived barriers to transitioning youth to adult health providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**

	DHC	ES	PBS	IB
1. Provide a greater focal point for transition, by diffusing transition responsibilities across the C&Y Branch and by inserting transition linkage responsibilities into job descriptions				X
2. Through the Health Resources and Services Administration (HRSA) grant's CHAT project, provide training, identify needed policy changes, identify and develop community resources, and provide information.				X
3. Continue training and TA to YSHCN, families and providers .				X
4. Provide TA on youth leadership development and access to health care to the NC Developmental Disabilities Council.				X
5. Collaborate with the School Health Program and other WCHS planning bodies, to include youth with disabilities in an advisory capacity for Title V programs.				X
6. Promote transition as a focus in planning for medical homes for CSHCN.				X
7. Continue to use the National Survey of Children with Special Health Care Needs data in planning transition efforts and galvanizing support.				X
8. Continue participation in the DHHS Eliminating Health Disparities Initiative.				X
9. Collaborate with provider associations, and other Departments to support transition.				X
10.				

b. Current Activities

FY10 activities included:

-CHAT finalized development of health care transition materials and fact sheets to be placed on various websites.

-The CHAT youth and family initiatives conducted trainings across NC. More than 30 family/youth workshops were conducted, and >18,000 educational brochures and resource materials were mailed statewide.

-MAHEC developed a series of web-based CME modules about transition for health care providers. Six fact sheets were developed and distributed to NC youth, families, and allied health providers about developmental disabilities, assistive technology, and patient-centered medical home.

-The CHAT project manager made presentations at the NC Annual School Nurse and NC Developmental Disabilities conferences.

-The PMC included information on transition issues for YSHCN in statewide presentations to medical residents, allied health providers, and social workers.

-The CHAT project manager and PMC participated in state and national transition efforts and shared information about best practices with key stakeholders.

-MAHEC published an article in the NC Medical Journal about the importance of health care transition for YSHCN. The special journal edition included information about transitions across the lifespan for people with developmental disabilities

-The CHAT project manager and MAHEC collaborated with the Center for Children with Complex and Chronic Conditions to conduct Quality Improvement workshops and projects.

c. Plan for the Coming Year

Plans to promote transition services for FY11 include the following activities:

-Disseminate and promote the CHAT youth, family and medical provider hard copy materials, DVDs and web based curriculum among state professional organizations, community based agencies and school nurses;

-Increase social marketing efforts by developing a state transition listserv to promote and sustain

ongoing communication among stakeholders, offering live and web-based trainings for health professionals to targeted groups throughout NC AHEC system, and using other social networking media such as Facebook and YouTube to increase exposure to issues related to health care transition; and
-ODH will work with DPH to increase transition outreach efforts with YSHCN through providers, families, and youth working together as partners in medical homes across the state.

The MAHEC mini-fellowship program will continue to support transition as a major topic area and promote the need to address transition for youth with developmental disabilities, as well as build a community of peers to define and advance the importance of healthcare transition in adult developmental medicine. The NC Health Care Transition Research Consortium will continue to engage national and international stakeholders to address research and policies related to health care transition.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	90	90	90
Annual Indicator	85.2	82.2	82.4	75.1	64
Numerator					
Denominator					
Data Source				National Immunization Survey	National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	90	90	90	90	90

Notes - 2009
Data are from the National Immunization Survey for the Q3 2008 to Q2 2009 time period (July 2008 to June 2009). As this is a weighted estimate, data for the numerator and denominator are omitted.

Notes - 2008
Data are from the National Immunization Survey for the Q3 2007 to Q2 2008 time period (July 2007 to June 2008). As this is a weighted estimate, data for the numerator and denominator are omitted.

Notes - 2007
Data are from the National Immunization Survey for the Q3 2006 to Q2 2007time period (July 2006 to June 2007). As this is a weighted estimate, data for the numerator and denominator are omitted.

a. Last Year's Accomplishments
The latest published National Immunization Survey (NIS) results showed that in FY09, North Carolina coverage dropped to 64.0% of children in the target age group being fully immunized (4:3:1:3:3). A review of the data for completion by antigen and for various series suggests that the factor pulling down North Carolina's coverage rate in FY09 was the completion of the required three dose series of Hib by age 35 months. The completion rate for Hib was 72.7%.

The impact of Merck's Pedvax Hib recall of December 2007 was particularly damaging for NC in comparison to many other states. The Pedvax Hib recall created an immediate deficit of 55,215 doses in North Carolina's Hib supply putting North Carolina providers over a month and a half behind schedule for the administration of Hib. The initial deficit from the Pedvax recall was not corrected. Pentacel, a combination Hib containing vaccine, became available in August 2008, but the average of North Carolina's monthly allocations only met 89% of overall need until November 2008. The deficit was not corrected until September 2009 when the comprehensive need for Hib vaccine dating from December 2007 (709,555 doses) was finally met. This extensive time lag in meeting North Carolina's need for Hib containing vaccine caused many children to not receive Hib vaccine on time.

The Assessment, Feedback, Incentive, eXchange (AFIX) program was reinstated. It was decided to separate AFIX from Vaccines for Children (VFC) site visits in order to provide more thorough training to private providers on how to use the North Carolina Immunization Registry (NCIR) assessment and reminder/recall tools to improve coverage rates among the children who are actively seen by them.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintenance of the Universal Childhood Vaccine Distribution Program.			X	
2. LHD assessment and tracking activities.				X
3. Complete at least 325 VFC/AFIX visits in calendar year 2010.		X		
4. Update the Immunization Branch web site as necessary.			X	
5. Continue deployment of the statewide registry to the remaining private providers.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
During FY10, North Carolina appealed to CDC to increase its allocation of Hib-containing vaccine. The deficit of Hib-containing vaccine experienced by NC beginning in December 2007 was corrected in September 2009. Adequate provision of Hib containing vaccine should help to improve the rates for the completion of the three dose Hib series and consequently the 4:3:1:3:3 series.

The Immunization Branch (IB) contracted with Hewlett Packard to reinstate statewide deployment efforts for the NCIR. The statewide deployment goal is to have at least 85% of providers on the NCIR by the end of FY10. Increased provider participation in the NCIR will help to ensure that client immunization histories documented in the NCIR are complete. IB staff members continue to train providers on the utilization of NCIR reminder/recall tool during VFC site visits and AFIX visits. Greater use of these tools by providers should help to increase the overall completion rate

of the 4:3:1:3:3 series in NC. In addition, inventory management training will be provided to all new NCIR providers at the time of deployment. VFC and AFIX site visit efforts were suspended from September 2009 through December 2009 due to the emergence of the H1N1 pandemic. Most IB staff members were pulled from regular activities to assist with the H1N1 emergency. Site visits resumed in January 2010.

c. Plan for the Coming Year

In June 2010, the UCVDP was discontinued due to a state budget shortfall. The state legislature cut all state funds to provide vaccines to the insured population which is approximately 33% of the children in the state. The newly named, North Carolina Immunization Program will continue to provide vaccine at no cost to qualified children through the federally funded Vaccines For Children program.

During FY11, over 85% of statewide deployment of the NCIR will be completed. Increased provider participation in the NCIR will help to ensure that client immunization histories documented in the NCIR are complete. IB staff members will continue to train providers on the utilization of NCIR reminder/recall tool during VFC site visits and AFIX visits. Greater use of these tools by providers should help to increase the overall completion rate of the 4:3:1:3:3 series in North Carolina. In addition, inventory management training will be provided to all new NCIR providers at the time of deployment. Additional IB staff members have been trained to conduct AFIX visits. The number of AFIX visits for childhood and adolescent immunizations are planned to increase.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	26.5	26	26	24	24
Annual Indicator	26.8	26.7	24.6	26.6	25.1
Numerator	4425	4519	4306	4775	4730
Denominator	165361	169277	175313	179620	188698
Data Source				NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**

Annual Performance Objective	24	24	24	24	24

Notes - 2008
The data source for the numerator is vital records as reported in the Basic Automated Birth Yearbook for 2007 on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

FY year data are actually the prior calendar year, e.g. FY08 is really CY07.

Notes - 2007
FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

a. Last Year's Accomplishments
Through the Teen Pregnancy Prevention Initiatives (TPPI), the NC DHHS invests in the young people of North Carolina by helping them gain the knowledge and skills they need today so they will be able to take care of themselves, their families, and their communities for the rest of their lives. TPPI provides four-year competitive grants to local agencies including public health departments, county departments of social services, school systems, and private non-profit agencies to prevent teen pregnancy and support teen parents.

The Adolescent Parenting Program (APP) helps teen parents prevent a subsequent pregnancy, graduate from high school, go on to post-secondary education or training, and improve the developmental outcomes for their children. The program is implemented by at least one full-time coordinator with a caseload of 15-25 first-time teen parents. Through individualized goal plans, intensive case management services, and group educational sessions, program participants are empowered to become self sufficient and build a better future for their babies.

Only 10, or 1.6%, of the 618 teen parents enrolled in APP in FY09 had a repeat pregnancy, while the overall repeat pregnancy rate among teens in North Carolina is 29.4%. In addition, while parenthood is the leading cause of school dropout among teen girls in the U.S., the dropout rate among APP participants was 5.99%, which is only one percent higher than the dropout rate among the general student population in North Carolina (4.97%). More than three out of four of the 155 APP graduates reported enrollment in post-secondary education, vocational training, or the military. Reports of abuse or neglect were filed on 7.8% of children ages 0-5 in North Carolina. With the support of APP, only 2.27% of children of APP participants were the subjects of reports of abuse or neglect, and only .49% (n=3) of those reports were substantiated.

An evaluation of one local APP was conducted by Dr. Ken Gruber, a researcher at the School of Human Environmental Sciences at the University of North Carolina at Greensboro. The findings of this comparative evaluation suggest that the graduates of APP were on a more positive life course than the cohort sample. There were significant differences in education attainment and current higher education enrollment, more job stability, greater living independence from parents and family, and greater focus on career goals, which are likely reflective of lessons learned or strengthened from the experience of being in APP. Given the young women's life path at the time they entered the program, most appear to have equaled and perhaps exceeded their peers in terms of achievement in their transition to adult and parenthood.

The Adolescent Pregnancy Prevention Program (APPP) prevents teen pregnancy by providing young people with essential education, supporting academic achievement, encouraging parent/teen communication, promoting responsible citizenship, and building self confidence among participants. Local agencies that are awarded pregnancy prevention funds are required to implement programs that have been shown through evaluation to be effective at reducing teen pregnancies. FY09 program evaluation revealed that APPP participants demonstrated increased knowledge, attitudes, and beliefs that support a delay in sexual activity or safer sex practices.

They also reported more careful and thoughtful decision-making, a decrease in alcohol or other drugs, increased condom use at last intercourse, and increased communication with their parents about sexual health.

Through 56 APP and APPP programs in 39 of the 100 North Carolina counties, approximately 5,500 young people between the ages of 10 and 18 in the state were served during FY09.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Ongoing support provided for Teen Pregnancy Prevention Initiative projects.		X		
2. Primary prevention projects participate in annual evaluation process				X
3. All TPPI projects participate in a web-based process evaluation program.				X
4. Annual Teen Pregnancy Prevention Symposium (with the Adolescent Pregnancy Prevention Campaign of NC).				X
5. Annual Adolescent Parenting Graduation Conference.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY10, 53 APP and APPP projects in 39 North Carolina communities are receiving TPPI funds. These projects included 25 primary prevention APPPs, and 28 secondary prevention APPs.

TPPI has continued to be committed to reducing teen pregnancy in the counties with the highest teen pregnancy rates and to eliminating health disparities. In response to the requests for applications during FY2010, TPPI received the best response ever from agencies in counties with teen pregnancy rates in the top quartile in the state. As many as 64% of all applications received were from counties with high teen pregnancy rates. In the previous year, the response rate from high-rate counties was only 30%. The increase is likely the result of saturating the high-rate counties with the funding announcement and additional face-to-face consultation with these counties than with lower rate counties.

The APPP continues to build the capacity of local projects to implement evidence-based approaches to preventing teen pregnancy. The request for applications released during FY10 included a short list of nine program models for applications to choose from. These program models were selected based on fidelity assurances such as training and monitoring by the program developer or by the Adolescent Pregnancy Prevention Campaign of North Carolina.

c. Plan for the Coming Year

The outcome evaluation plan for the APPP will continue to be improved in an effort to establish the efficacy of these primary prevention programs. Local program coordinators have received training and consultation on how to identify an appropriate control group. The evaluation survey has undergone substantial revisions, and local program coordinators received consultation on best practices for administering the surveys to the participants and comparison group members.

The survey will be completed electronically by some local program participants and comparison group members, which will reduce data entry error and streamline the data processing process. This will enable evaluation reports to be produced more quickly, allowing state and local staff to make more timely program planning decisions.

TPPI will continue to increase the implementation of evidence-based approaches to teen pregnancy prevention by local contractors receiving funding for primary prevention programs. Respondents to the Request for Applications (RFA) will continue to be required to choose a proven program model for implementation. TPPI program consultants will also begin monitoring the fidelity with which local projects are implementing the chosen program model.

TPPI will continue to focus on addressing ethnic and racial disparities among Hispanic/Latino youth. The FY11 RFAs will strongly encourage applications that will serve this population. One of the fundable program models listed in the primary prevention RFA will be Cuidate: Take Care of Yourself, which is a culturally relevant curriculum for Latino youth. The TPPI staff continues to establish collaborative relationships with other state and local government agencies, private organizations, and local Hispanic-focused efforts. Efforts to identify specific program objectives that address reductions in racial disparities in health indicators at the local level will continue.

The APP will be developed to include an educational curriculum for group sessions. The TPPI staff continues to research possible curricula to be used. TPPI is also currently applying for a federal grant from the Office of Adolescent Health to conduct a rigorous 5-year evaluation of the program.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	50	50	50	50
Annual Indicator	43.0	44.0	42.0	45.0	44.0
Numerator	33793	35453	36285	36234	37835
Denominator	78588	80574	86393	80521	85988
Data Source				DPH Oral Health Section Surveillance System	DPH Oral Health Section Surveillance System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	50

Notes - 2009

These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

Notes - 2008

These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

Notes - 2007

These data are based on fifth graders, not third graders. In North Carolina, the surveillance system used to measure the percentage of elementary school children who have received protective sealants on at least one permanent molar tooth was set up to measure fifth graders before the national standard was set at third graders. Data collected in an epidemiologic survey conducted in 1986-87 did not show a statistically significant difference between the percentage of third graders and the percentage of fifth graders.

a. Last Year's Accomplishments

During the 2008-09 school year, data was collected on 85,988 fifth grade schoolchildren (77%). The proportion who had dental sealants was 44 percent. As part of state supported sealant promotion projects, and using a small supplement from Preventive Health and Health Services Block Grant funding, the Oral Health Section (OHS) provided 14,573 sealants for 4,108 children during 57 sealant projects.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide dental assessment of oral health status conducted in alternate school years (even years).			X	
2. Staff driven and community-based sealant projects conducted.	X			
3. Educational services provided in various settings.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In FY10, the OHS will once again focus on providing dental sealants for schoolchildren at high-risk for dental decay. Over the years, funding from the Preventive Health and Health Services Block Grant has decreased by 70%. Additionally, two field hygienist positions were lost last year and a number of staff retirements are anticipated. Further, two dentist positions were lost last year, so the number of dentists working with sealant projects has declined from five to three -- a 40% loss in capacity. Therefore, OHS hopes to provide approximately 11,000 sealants.

c. Plan for the Coming Year
Assuring that children at high risk for tooth decay get dental sealants continues to be one of the OHS's top priorities. Preventive Health and Health Services Block Grant funds have decreased dramatically. Getting parental permission for their children to get sealants is increasingly difficult. This problem does not seem particular to sealants, but just that communication between schools and parents is getting more and more difficult - permission slips are sent home, but never seen by parents or returned to school by the children. There could also be growing concern regarding patient information and the desire for privacy. Even with these barriers, however, OHS hopes to continue to provide sealants to those children at highest risk.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4	4	4.5	4.5	4
Annual Indicator	5.5	4.7	5.0	4.0	3.0
Numerator	96	82	90	73	54
Denominator	1731988	1751959	1788230	1823562	1829372
Data Source				NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	3	3	3	3	3

Notes - 2009
Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

Data are for the calendar year preceding the fiscal year (2009 data are for CY2008).

Notes - 2008
Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The

source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

Data are for the calendar year preceding the fiscal year (2008 data are for CY2007).

Notes - 2007
Data are for the calendar year preceding the fiscal year (2007 data are for CY2006).

a. Last Year's Accomplishments
The NC Child Fatality Task Force (CFTF) focused its motor vehicle safety efforts around children going to school. To combat drivers "running" stopped school buses, the CFTF successfully pursued legislation which assures that pictures taken of drivers committing stop arm violations are acceptable court evidence. It also makes it a felony if a student is killed due to an illegal pass of a stopped school bus. The CFTF is also working with the Department of Motor Vehicles (DMV) to request that the school bus stop arm icon is included on DMV vision tests.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued review of child deaths due to motor vehicle crashes on the state and local levels.				X
2. CFTF advocates for new legislation aimed at preventing child deaths from motor vehicle crashes.				X
3. Community car seat distribution programs.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Alcohol (or other substance use) contributes to more than 15% of child deaths (ages 0 to 17) from motor vehicle crashes. Forensics Testing for Alcohol (FTA) provides important supports to help detect and deter alcohol use, including maintaining equipment, training personnel in equipment use, and conducting highly visible "Booze It and Lose It" campaigns. The CFTF has recommended increasing the fee by $25 (from $100 to $125) to restore a driver's license following a civil revocation with funding going to FTA to maintain and strengthen their program.

The CFTF has also continued its work with NCIOM Task Force on Adolescent Health. The goal of the NCIOM Task Force is to increase awareness of the unmet needs of North Carolinians ages 10-20, and to develop a detailed strategy to address the high-priority health needs. In December 2009 recommendations were unveiled, including those designed to reduce motor vehicle crashes. The C & Y Branch reallocated a position to work as an Adolescent Health Coordinator to develop and implement a preventive health care system for adolescents. The hiring process has begun.

In conjunction with the State Fire Marshall, the CFTF is exploring the possibility of identifying federal money to conduct local training around safe usage of all terrain vehicles.

CFTF continues to monitor factors that contribute to child deaths in motor vehicle crashes.

c. Plan for the Coming Year
The NC CFTF will focus on improving driver education training, child safety in school zones, and seat belt compliance. A work group of issue experts and stakeholders has been formed on driver education to examine how to most effectively use money already transferred from the Department of Transportation (DOT) to DPI to enhance driver's education courses across North Carolina. Experts, including those from DOT, DPI, Safe Routes to Schools, and the School Boards Association, have begun to weigh-in on strategies to improve signage and other measures to enhance school zone safety. The CFTF plans to work with DOT on strategies to improve seat-belt wearing, especially in the backseat.

Additionally, by January 2011, the CFTF plans to make recommendations to reduce child fatalities due to unintentional injury, likely including motor vehicle related deaths. Issues under preliminary discussion currently include raising the beer tax to deter underage drinking and drunk driving, making it illegal to possess a fake ID, and making it a felony to be charged with driving while impaired with a child in the vehicle.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		15.5	15.5	16.5	17
Annual Indicator	15.0	15.5	16.2	16.8	17.3
Numerator	11570	12379	13692	14678	15436
Denominator	76949	80019	84574	87504	89168
Data Source				WIC data - NC Health Services Information System	WIC data - NC Health Services Information System
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	17.5	17.5	17.5	18	18

Notes - 2009
Data are for CY08. CY09 data will be available in March 2011. Calendar year data are delayed due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

Notes - 2008
Data are for CY07. CY08 data will be available in March 2010. Calendar year data are delayed due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

Notes - 2007
Data are for CY06. CY07 data will be available in March 2009. Calendar year data are delayed due to waiting for the 6 month duration time and including time to verify the data. Data are on WIC participants only as population data are not available.

a. Last Year's Accomplishments
According to the 2006 CDC National Immunization Survey, North Carolina has not met any of the HP2010 breastfeeding goals of 75% of mothers ever breastfeeding (NC=66.9%), 50% of mothers breastfeeding at 6 months (NC=36.7%), and 25% of mothers breastfeeding at 12 months (NC=18.9%). Additionally, the state's rate for "exclusive" breastfeeding at 6 months is 13.1%, lower than the national average of 13.6%. The 2006 data compared to 2003 data show a decline in the percent ever breastfeeding (2003 data = 68.4%), no movement at all in the percent breastfeeding at 6 months, and an almost twenty percent increase in the percent breastfeeding at 12 months (2003 data = 15.8%). The percent of women exclusively breastfeeding at six months also increased from 12.1% in 2003.

Activities undertaken by the Nutrition Services Branch (NSB) in FY09 to further increase breastfeeding duration rates included:
-collaborating with the NC Breastfeeding Coalition to build a statewide infrastructure for breastfeeding support;
-developing an RFA to expand the number of Regional WIC Lactation Resource and Training Centers from three to six;
-revising materials and activities related to the promotion of breastfeeding-friendly workplaces;
-collaborating with the Division of Child Development to revise their Child Care Manual related to breastfeeding;
-offering training on breastfeeding to child care providers participating in the Child and Adult Care Food Program (CACFP);
-developing a competency based pump training and certification requirement for local WIC Program staff who "issue" breast pumps and kits;
-collaborating with the NCHSF on a breastfeeding social marketing campaign in Eastern NC; and
-collaborating with the NC CFTF to implement breastfeeding support recommendations for workplace policy and a maternity center based awards system.

Continuing activities of the NSB in FY09 include:
-co-sponsoring the NC Lactation Educator Training Program (NCLETP) (94 completed);
-promoting implementation of activities in the breastfeeding state plan;
-conducting a Vitamin D distribution program for exclusively breastfed infants;
-promoting World Breastfeeding Week;
-supporting accurate breastfeeding data collection and analysis;
-providing breastfeeding aides (i.e., hospital grade electric, single-user electric, manual breast pumps and pump kits), professional resources, and client educational materials to local WIC agencies; and
-enhancing existing local WIC Program breastfeeding peer counselor programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Expansion and enhancement of Breastfeeding Peer Counselor Programs.		X		
2. Promote and recognize World Breastfeeding Week annually.			X	
3. Offer the North Carolina Lactation Educator Training Program two times a year.				X
4. Distribute electric & manual breast pumps and accessory kits to local WIC agencies throughout the state.		X		

5. Enhance and support accurate breastfeeding data collection and analysis.				X
6. Establish & maintain a Regional WIC Lactation Training Center in each perinatal region.				X
7. Assure local agency public health staff receive training in breastfeeding support & lactation management.				X
8. Offer training and consultation targeted toward childcare industry on breastfeeding and pumped breastmilk.				X
9. Distribute & promote a North Carolina plan for promoting, protecting and supporting breastfeeding.				X
10. Launch the NC Maternity Center Breastfeeding Friendly Designation.				X

b. Current Activities

New activities undertaken in FY10 included:
-establishing two Regional WIC Lactation Training Centers, bringing the total to five;
-statewide expansion of the WIC Breastfeeding Peer Counselor Program;
-developing materials about breastfeeding and the new WIC food package;
-funding a $12,000 mini-grant in five perinatal regions to implement activities promoting breastfeeding friendly workplaces and provide continuing education to medical professionals;
-developing a maternity center designation for hospitals and birthing centers adopting breastfeeding friendly practices; and
-assisting the NC Breastfeeding Coalition with the Business Case for Breastfeeding strategic plan.

Continuing activities include:
-developing a competency based pump training and certification requirement for local WIC Program staff;
-working with the NC Breastfeeding Coalition to build a statewide infrastructure for breastfeeding support;
-co-sponsoring the NCLETP;
-conducting a Vitamin D distribution program for exclusively breastfed infants;
-promoting World Breastfeeding Week;
-supporting data collection and analysis;
-promoting activities in child care agencies;
-providing breastfeeding aides, professional resources, and client educational materials to local WIC agencies;
-working with the NCHSF on a social marketing campaign; and
-working with the NC CFTF and the Office of State Personnel (OSP) on breastfeeding support recommendations for workplace policy.

c. Plan for the Coming Year

New activities planned by the NSB for FY11:
-implementing a competency based pump training and certification requirement for local WIC Program staff who "issue" breast pumps and kits;
-providing train-the-trainer workshops for local agency WIC Breastfeeding Coordinators using the national "WIC Grow and Glow" curriculum;
-implementing a sixth Regional WIC Lactation Training Center;
-funding mini-grants to local WIC Programs for breastfeeding promotion and support activities;
-implementing a maternity center designation for hospitals and birthing centers adopting breastfeeding friendly practices;
-assisting the OSP with implementing the new worksite lactation policy;
-convening a group of stakeholders to assess the breastfeeding state plan to identify accomplishments and areas for improvement; and

-holding a summit for child care health consultants and statewide leaders in the area of child care to focus training and promotion efforts statewide.

Continuing activities of the NSB in FY11 to promote and support breastfeeding include:
-collaborating with the NC Breastfeeding Coalition to build a statewide infrastructure for breastfeeding support;
-assisting the NC Breastfeeding Coalition with the Business Case for Breastfeeding strategic plan;
-co-sponsoring the NCLETP twice;
-promoting World Breastfeeding Week;
-supporting accurate breastfeeding data collection and analysis;
-providing breastfeeding aides, professional resources, and client educational materials to local WIC agencies; and
-enhancing existing local WIC Program breastfeeding peer counselor programs.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	90	90	97	97	98
Annual Indicator	87.4	96.8	94.6	94.6	95.2
Numerator	106880	119164	123107	126258	125895
Denominator	122274	123045	130067	133450	132252
Data Source				WCSWeb Hearing Link	WCSWeb Hearing Link
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	98	98	98	98	98

Notes - 2009
Prior to 2005, “before hospital discharge” was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based on this concern, the operational definition of “before hospital discharge” was changed to include all babies screened for hearing loss within 30 days of birth.

Notes - 2008
Prior to 2005, “before hospital discharge” was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based on this concern, the operational definition of “before hospital discharge” was changed to include all babies screened for hearing loss within 30 days of birth.

Notes - 2007
Prior to 2005, “before hospital discharge” was operationally defined by WCHS as within 48 hours of birth. However, this operational definition did not take into account babies born by cesarean section and infants admitted to a NICU who have hospital stays of longer than 48 hours. Based on this concern, the operational definition of “before hospital discharge” was changed to include all babies screened for hearing loss within 30 days of birth.

a. Last Year's Accomplishments
All 87 hospitals/birthing facilities in NC provide newborn hearing screening. Data from the state's web-based data tracking and surveillance system for newborn hearing screening, WCSWeb Hearing Link (WCSWeb), for calendar year 2008 indicated:
-Live Births = 132,252
-Total Screened = 131,133
-Total % Screened (regardless of age) = 99.2% of the live births
-Total Screened by 1 month of age = 125,895
-Total % Screened by 1 month of age = 95.2% of the live births (or 96.0 % of babies screened) were screened for hearing loss before leaving the birthing facility.

Prior to 2005, "before hospital discharge" was operationally defined by WCHS as within 48 hours of birth. However, this definition did not take into account babies born by cesarean section and infants admitted to a Neonatal Intensive Care Unit (NICU) who have hospital stays of more than 48 hours. Based on this concern, the operational definition of "before hospital discharge" was changed to include all babies screened for hearing loss within 30 days of birth.

All birthing hospitals continue to implement their newborn hearing screening programs. Seventy-five hospitals provided outpatient rescreens and several other hospitals began development of similar protocols. All hospitals have completed Program Plans for newborn hearing screening.

WCSWeb, our newborn hearing tracking system, was implemented in 13 more hospitals, bringing the total to 44 hospitals using the system. All hospitals on WCSWeb are trained to do direct data entry for demographic information and hearing screening results. WCSWeb was used to determine data for the most recent (calendar year 2008) Hearing Screening and Follow-up Data Report for CDC, and is now able to provide data on the number of babies screened and the percent that pass or are referred on a hospital-by-hospital basis.

A system to keep track of needed enhancements to WCSWeb continued to be used, and a CDC Cooperative Agreement was continued to help support these improvements as well as tracking and surveillance activities.

The child health speech and audiology consultants provide ongoing technical assistance, consultation, and support to hospitals and healthcare providers. Audiology consultants train LHD staff to use otoacoustic emission tests (OAE) for hearing screening and tympanometry for possible otitis media. Centralized data staff provided tracking and surveillance for all 100 counties.

The EHDI Advisory Committee, including five parents, met quarterly. Subcommittees continued to address specific concerns.

OAE screening was conducted by nurses in LHDs. Child health speech and hearing consultants provided training to these nurses.

MCHB also awarded a grant to NC for its EHDI Follow-Up project to increase access to audiological diagnostic services in two underserved regions and to develop materials that will assist all birthing facilities and rescreening sites to improve the number of families who return for needed follow-up.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Enhancements to the Newborn Hearing Screening Data Tracking and Surveillance System.			X	
2. Provide support to the local newborn hearing screening programs in birthing/neonatal facilities.				X
3. Identification of educational needs for pediatric audiologists, midwives, and primary care providers.				X
4. Regional staff assuring that all infants have access to screen and rescreen.		X		
5. Infants tracked through the screening, evaluation, and amplification process to assure no children missed.			X	
6. Development and implementation of training opportunities for pediatric audiologist, midwives, and primary care providers.				X
7. Coordination of referrals and information sharing for intervention services.				X
8. Development and implementation of EHDI data quality assurance plan.				X
9. Development and distribution of educational materials to hospitals, families, and providers.			X	
10. Regional staff providing support to families of children needing a diagnostic hearing evaluation.		X		

b. Current Activities

Hospitals continue their newborn hearing screening programs with regional consultants providing support and education. All hospitals complete detailed Program Plans. Training for hospitals on WCSWeb continued.

The EHDI Advisory Committee used subcommittees to address specific implementation and evaluation issues.

NC EHDI participated in the NICHQ by working with two hospitals to develop comprehensive rescreening programs and educating other hospitals about these programs.

Letters explaining the Joint Committee on Infant Hearing 2007 standards were sent to hospital administrators. Regional consultants provide quarterly statistics to nursery staff.

Development of a newborn hearing screening brochure for hospitals was completed and distributed to hospitals.

Physician education regarding the EHDI process increased. Packets with information are distributed to physicians caring for a child diagnosed with hearing loss. Consultants or Advisory Board members presented information at hospital grand rounds. Parental education increased with the development of materials distributed to hospitals, physicians, midwives, etc.

Funding for first time hearing aids, batteries, and ear molds for a year, free of charge to families, was reinstated in FY10. Notifications were sent to all providers that the Branch would cover all claims that were submitted or denied during SFY09.

HRSA funding increased for development of teleaudiology diagnostic services in eastern NC.

c. Plan for the Coming Year
Hospitals will continue their newborn hearing screening programs. Regional speech and hearing consultants will continue to provide ongoing support to hospitals and provide in-services about newborn hearing screening. All hospitals will complete annual Program Plans detailing their newborn hearing screening program.

Training for hospitals to use WCSWeb will continue. Additional hospitals will be systematically trained to be able to use this system to report hearing screening results. Development of enhancements to WCSWeb will continue into 2011.

Regional child health audiology consultants will continue to provide training for local health department staff to use OAE and tympanometry.

The EHDI Advisory Committee will continue to meet quarterly. The subcommittees that address specific issues will provide ongoing guidance in the implementation and evaluation of the program. Families are members of this Committee.

The EHDI Program will continue to implement quality improvement methodology learned through participation in the NICHQ. Small group evaluation of materials and activities will be utilized to determine effectiveness prior to large scale implementation.

Regional consultants will continue to provide quarterly statistics to nursery staff at each hospital. Quarterly statistics will also be shared with quality improvement staff at individual hospitals as needed.

Improved notification for audiology providers will be implemented during the fiscal year.

Development of a second version of the newborn hearing screening brochure for hospitals will be completed and will be distributed to all hospitals that do not have hospital specific brochures. Brochures will be available in English and Spanish and will be translated into the five other most prevalent languages spoken in NC.

Physician education regarding the EHDI process, including best-practices for rescreening and diagnostic evaluation will continue. Notebooks with information about hearing loss in children and the EHDI system will be distributed to any physician caring for a child newly diagnosed with hearing loss. Regional consultants and EHDI Advisory Board members will continue to present information at hospital grand rounds and other venues as needed. An outreach effort, including providing information to medical students and residents, will continue at medical schools in the University of North Carolina system.

Parental education about EHDI will continue and additional materials will be developed and distributed to hospitals, physicians' offices, midwives, etc.

The Teleaudiology Project, funded by HRSA, will be fully implemented in a limited number of sites within an established telemedicine network. An additional site will be identified and developed in a location with significant Native American population.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	10	10	10	10	10

Annual Indicator	12.0	11.6	13.1	13.3	11.3
Numerator	266980	266110	302690	310673	271600
Denominator	2231120	2299390	2314354	2340346	2407700
Data Source				Urban Institute & Kaiser Comm Medicaid & Uninsured	Urban Institute & Kaiser Comm Medicaid & Uninsured
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	10

Notes - 2009
FY09 Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2008 and 2009 Current Population Surveys for children <18. (CPS: Annual Social and Economic Supplements). Accessed at following url: http://www.statehealthfacts.org.

Notes - 2008
FY08Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2007 and 2008 Current Population Surveys for children <18. (CPS: Annual Social and Economic Supplements). Accessed at following url: http://www.statehealthfacts.org.

Notes - 2007
FY07Data Source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2006 and 2007 Current Population Surveys for children <18. (CPS: Annual Social and Economic Supplements).

a. Last Year's Accomplishments
By March 31, 2009, there were 127,857 children enrolled in NC Health Choice (NCHC) and 809,593 in Health Check (HC). 2006-07 Current Population Survey (CPS) data as reported through the Kaiser Family Foundation website shows that 13% of children <=18 years old were uninsured (many due to loss of employer-sponsored coverage).

The state outreach coalition and their strategic plan guided our work in FY09:
-Developed infrastructure with new outreach partners: DPI's Healthy Schools Section/School Health Advisory Councils; NC Justice Center's Health Access Coalition; NC Association of Health Insurance Underwriters; 211 Resource Line; and NC Community College System's Small Business Center Network. Worked with Action for Children NC and Earned Income Tax Credit Carolinas (EITC Carolinas) to publish "Making Ends Meet: A NC Resource Guide."
-Enhanced existing partnerships (e.g., HC/NCHC outreach message in new School Lunch

automated approval letters reaching ~1/2 million children that result from Temporary Assistance to Needy Families (TANF)/Food Stamps file matches, work with DMA to establish a standard and monthly reporting for Health Check Coordinators (HCCs) on grassroots outreach to Community Based Organizations (CBOs).
-Began work with Robert Woods Johnson, NCPS, and DMA on enrollment/re-enrollment process enhancements.
-Increased trust/partnership with minority communities due to development of fact sheets in six new languages and joint efforts to reach families.
-Lessons learned from surveys/focus testing of professionals and families related to outreach/education materials that will enhance content and promotion.
-Web development to enhance sites for the public, professionals, and outreach workers. Published online "news" articles to keep local staff updated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain HC/NCHC Outreach Campaign in partnership with the NC Healthy Start Foundation.			X	
2. Simplification of enrollment/re-enrollment forms and continued development of family-friendly notices.		X		
3. Development of comparable data sets for HC and NCHC.				X
4. Targeted outreach to special populations (including minority and CSHCN).			X	
5. Development of infrastructure to promote and sustain HC/NCHC outreach.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
On 3/31/2010, 132,508 children were enrolled in NCHC; 849,004 in HC. 2007-08 CPS data report 11.3% of children <=18 years old are uninsured.

Due to recession, unemployment, and reduced tax revenues, the infrastructure for HC/NCHC outreach was significantly impacted. The NC Family Health Resource Line closed in 11/09. The line handled ~35,000 calls per year with ~65% being HC/NCHC-related. The NCHSF contract, through which the state designs, prints and distributes outreach materials and maintains a web site, was not executed until six months into the SFY. HCCs experienced a reduction in force. By 1/31/2010, 110 HCC positions were reduced to ~35 statewide. Job responsibilities have been reprioritized and do not include outreach for the foreseeable future. C&Y Branch staff had travel restrictions/insufficient resources to sustain the level of outreach accomplished in years past.

Despite setbacks, C&Y Branch staff have:
-been involved in development and implementation of NC's CHIPRA Outreach Grant;
-worked on implementation of enrollment/re-enrollment simplification strategies;
-posted a School Partnership web site (a one-stop-shop for school partners);
-distributed "Making Ends Meet" Resource Guides to care coordinators/families;
-developed strong relationships with CBOs and faith-based organizations within the Latino, refugee/immigrant, American Indian, and African American communities; and
-partnered with agencies serving the homeless and providing low income housing.

c. Plan for the Coming Year
The number of uninsured children in NC appears to have declined slightly from 13% of children <=18 years old in 2006-07 to 11.3% of children in 2007-08 according to CPS data. However, employer-sponsored health insurance coverage for dependents <= 18 years continued to decline in 2007-08 to 49.8% of all children (down from 53.2% in 2006-07 and 63.3% in 2000-2001).

While federal CHIPRA legislation offers opportunities to enhance outreach and enroll new children, the state budget crisis undermined progress due to loss of critical infrastructure. NCHC faces a 3% enrollment growth cap in FY11. The NC Coalition to Promote Health Insurance for Children and state staff are focusing on strategies in three priority areas:

1) Health Check Enrollment:
-Children <6 years: NC's CHIPRA Grant called "Healthy and Ready to Learn" is targeting children entering kindergarten. Work with child care, Head Start, Smart Start, More-at-Four, and Pre-K partners to continue.
-Unemployed, under-employed and those who have lost employer-sponsored coverage: Work with the NC Department of Insurance to assure that families who are laid off or lose employer-sponsored coverage are told about HC/NCHC. Encourage small business employers to offer HC/NCHC as an option. Partnership with ESC, other means-tested programs, and Connect Inc. (a toll-free resource that connects families to support services) will continue.
-Homeless; families whose homes are in foreclosure; low income housing applicants: Work through local HUD agencies, NC Housing Coalition, homeless shelters, and food banks.
-Targeted outreach to CSHCN and minority populations (including immigrants/refugees) to impact health disparity issues: With the support of the NCGA, DHHS/DMA submitted a state plan amendment to the Centers for Medicare and Medicaid Services (CMS) for adoption of the CHIPRA option to waive the 5-year waiting period for legal immigrants. Recruit community partners within CBOs to become "trained" HC/NCHC Application Assistors.
-Outreach through safety net providers: Free clinics, community health centers, health departments, hospital emergency departments.
-Continued outreach through Free and Reduced Price School Lunch Program: The Free Lunch Express Lane automatic enrollment through the file match with TANF) and Supplemental Nutrition Assistance Program continues to be a great opportunity for HC/NCHC outreach.

2) Simplification Strategies Related to Enrollment/Retention:
-A Simplification Committee is considering Express Lane Eligibility, Automatic Renewal (Exparte Review), or Premium Assistance Options. Adopting one of these options would allow NC to receive the CHIPRA Performance Bonus.

3) Development and Implementation of an Electronic Database to Screen Families for Multiple Means-Tested Programs:
-NC is currently developing their version of the Benefits Bank, a private proprietary product. MDC and Connect Inc. are leading this process.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		25	25	25	25
Annual Indicator	30.1	29.3	30.4	31.0	31.6
Numerator	20837	23750	27491	24719	28453
Denominator	69138	80955	90390	79667	89904
Data Source				NC-NPASS (Nut	NC-NPASS (Nut

				& PA Surveillance System)	& PA Surveillance System)
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	25	25	25	25	25

Notes - 2009
Data Source: NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) The subselection of WIC has been done from the composite NC-NPASS file. The annual composite file is created by combining the records from the WIC, Child Health and CSHS. The first records are kept during unduplication. So if a child visits the Child Health clinic first followed by WIC on a different day, the child health record would be kept provided the heights and weights are available. So depending on how a visit occurs, the numbers could vary from year to year and as such the numbers are very much dependent on which records gets selected.

Notes - 2008
Data Source: NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) The subselection of WIC has been done from the composite NC-NPASS file. The annual composite file is created by combining the records from the WIC, Child Health and CSHS. The first records are kept during unduplication. So if a child visits the Child Health clinic first followed by WIC on a different day, the child health record would be kept provided the heights and weights are available. So depending on how a visit occurs, the numbers could vary from year to year and as such the numbers are very much dependent on which records gets selected.

Notes - 2007
Data Source: NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) The subselection of WIC has been done from the composite NC-NPASS file. The annual composite file is created by combining the records from the WIC, Child Health and CSHS. The first records are kept during unduplication. So if a child visits the Child Health clinic first followed by WIC on a different day, the child health record would be kept provided the heights and weights are available. So depending on how a visit occurs, the numbers could vary from year to year and as such the numbers are very much dependent on which records gets selected.

a. Last Year's Accomplishments
Data for this measure have remained at about 30% for the past five years, with the 2008 data giving a rate of 31.6%, leaving much room for improvement.

FY09 activities included:
-implementing a "Move to Lower Fat Milk" education campaign and policy that children over 2 years of age who participate in WIC no longer receive whole milk (unless medically prescribed), but instead have a "point-of-purchase" choice of skim, 1%, or 2% milk;
-revising the Nutrition Assessment and Care Plan form used to document services for children in WIC to assess nutrition and physical activity behaviors related to achieving a healthy weight and offering training on these forms and assessment activities; and
-offering training to local WIC Program staff on using mini-lessons to effectively provide nutrition

education and distributing tool kits for "WIC mini nutrition education lessons" for preschool education.

Ongoing activities included:
-continuing development of the on-line Pediatric Nutrition Course (PNC) by pilot testing Module 1: Nutrition Assessment;
-promoting and supporting breastfeeding;
-expanding the utilization of Medicaid funded Medical Nutrition Therapy (MNT) services for children;
-offering training to local public health nutritionists on motivational interviewing;
-offering training to child care staff on the "Fit Nutrition For Preschoolers" toolkit,
-using NC-Nutrition and Physical Activity Surveillance System (NC-NPASS) data to monitor pediatric overweight;
-identifying resources for local WIC staff to use in their efforts to promote healthy weight in children; and
-implementing Value Enhanced Nutrition Assessment (VENA) activities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhancement of Nutrition and Physical Activity Surveillance System (NC-NPASS).				X
2. Education of health care professionals/staff training.				X
3. Education of children and their parents/caretakers.		X		
4. Continuation and expansion of Nutrition and Physical Activity Self Assessment for Child Care.				X
5. Implement WIC program policies supportive of dietary change.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
FY10 activities include:
-implementing federally mandated changes to the WIC Food Package so that it more closely aligns with the Dietary Guidelines For Americans and offers greater flexibility to meet cultural and nutritional needs of program participants. With the changes, children will be receiving fruits and vegetables and whole grain breads, grains, and cereals.
-implementing educational activities to support the changes in the food package and targeting seven "Healthy Habits, Healthy Families" behaviors. The targeted behaviors are breast feed your baby, increase fiber, lower the fat, eat more fruits and vegetables, eat more whole grains, drink less juice and sweetened beverages, and make family meals matter.
-implementing the PNC Module 1; and
-applying for a USDA Child Care Wellness Grant.

Continuing activities include:
-offering training to local WIC Program staff on using mini-lessons to effectively provide nutrition education and distributing tool kits;
-continuing development of the PNC by pilot testing Module 2: Basic Nutrition;
-promoting and supporting breastfeeding;
-expanding the utilization of MNT services for children;
-offering training to local public health nutritionists on motivational interviewing;

-offering training to child care staff on the "Fit Nutrition For Preschoolers" toolkit,
-using NC-NPASS data;
-identifying resources for local WIC staff to use to promote healthy weight in children; and
-implementing VENA activities.

c. Plan for the Coming Year
FY11 new activities include:
-offering training to local WIC Program staff on developing a summary statement for the WIC nutrition care plan;
-offering training to local WIC Program staff on the Breastfeeding Peer Counselor Program;
-offering training to child care staff on Grow It, Try It, Like It;
-implementing the PNC Module 2: Basic Nutrition; and
-implementing a USDA Child Care Wellness Grant (contingent on being awarded funding).

Continuing activities include:
-offering training to local WIC Program staff on using mini-lessons to effectively provide nutrition education and distributing tool kits for "WIC mini nutrition education lessons" for preschool education;
-continuing development of the PNC by pilot testing Module 3: Nutrition for Specific Conditions;
-promoting and supporting breastfeeding;
-expanding the utilization of Medicaid funded MNT services for children;
-offering training to local public health nutritionists on motivational interviewing;
-using NC-NPASS data to monitor pediatric overweight;
-identifying resources for local WIC staff to use in their efforts to promote healthy weight in children; and
-implementing VENA activities.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		12	12	11	10
Annual Indicator	12.5	12.1	11.5	11.0	10.4
Numerator	14959	14839	14668	14426	13621
Denominator	119773	123040	127646	130886	130758
Data Source				NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	10

Notes - 2009
Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here are CY08 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data obtained through vital records from the NC State Center for Health Statistics. The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

Notes - 2008
Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here are CY07 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data obtained through vital records from the NC State Center for Health Statistics. The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

Notes - 2007
Data for this measure are not available at this time as the 2003 birth certificate has not yet been implemented in NC. The data included here is CY06 data for the percentage of women who smoked during pregnancy, not just in the last three months, according to birth certificate data. The annual performance objectives are also based on women who smoked during pregnancy, not just in the last three months.

a. Last Year's Accomplishments
The LHD Maternal Health Agreement Addendum has mandates that all LHDs comply with the following criterion, which is monitored via the maternal health audit tools:

"The Health Department shall provide the 5A method for tobacco cessation to all pregnant and postpartum women using the 5As (ask, advise, assess, assist, arrange) as recommended by ACOG and referral made to appropriate community resource or the NC Tobacco Use Quit Line at 1-800-QUIT-NOW. Another resource is the "Guide for Counseling Women who Smoke, March 2008"." (Guidelines for Perinatal Care, p. 94-96)

The NC State Maternal Health Psychosocial Screening Forms have also been updated to assess for tobacco use during pregnancy, not only on the initial intake, but during every pregnancy trimester and postpartum. The direct questions which are asked on initial intake are as follows:
Do you smoke or chew tobacco or dip snuff? Do others smoke around you?
Trimester and Postpartum Questions:
Since the last time we asked you, have you started smoking, chewing tobacco or dipping snuff?

Through a contractual relationship with NCHSF, the Women's Health Branch (WHB) reprinted for distribution 80,000 pieces of Oh Baby, the self-help workbook on protecting children from secondhand smoke and distributed teen smoking cessation materials to 27 adolescent pregnancy agencies. Interactive pages regarding nicotine dependence and smoking and pregnancy were updated to the NCHSF's English and Spanish sites. This update included the addition of the plain-text version of A Guide for Counseling Women Who Smoke (for providers) to coincide with the previously released video. Ninety mini-grants to address women's health issues including smoking cessation were also awarded. Continuing to increase awareness of the impact of smoking on infant health, NCHSF worked on the Branch's behalf distributing 6,000 onesies for newborns with a message reinforcing the importance of safe sleep environments to 29 hospitals in the state.

Healthy Beginnings and the TIMR program served 1,478 pregnant women in FY09. There were 704 babies born and of those babies born, 94 were of low birthweight and there were 6 infant deaths. Both programs continue to use environmental tobacco reduction and elimination as a focus area. In FY09, 55 women smoked during their pregnancy while 20 stopped smoking during

their pregnancy.

Perinatal Outreach Coordinators (POCs) continued to provide smoking cessation training to perinatal healthcare providers in local health departments, community-based organizations, private practices, and other sites. In FY09, the Perinatal Outreach Coordinators conducted 13 tobacco cessation counseling specific training sessions reaching 63 providers.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Update and distribute The Guide for Counseling Women Who Smoke and other educational materials.			X	
2. Facilitate and manage the Women and Tobacco Coalition for Health activities.				X
3. Develop/sustain partnerships with women's health and tobacco use prevention/cessation organizations.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

With the assistance of NCHSF, NC Family Health Resource Line (until its closing in November 2009), and CARE-LINE, the WHB continues to reprint and distribute materials as needed for consumers and trainings. Current projects also include the research and production of short video messages on infant safe sleep practices to post on NCHSF website.

Healthy Beginnings and TIMR continue to do education sessions in group and home settings regarding tobacco use and its link to undesired birth outcomes. Referrals to appropriate resources are made when mothers or other family members show a desire to eliminate their tobacco use. A new RFA was released this year, and tobacco reduction and elimination will be a focus area for all future grantees.

POCs provided smoking cessation training to perinatal healthcare providers in LHDs, CBOs, private practices, and other sites. The "Getting Started" and "5A's Counseling" sections of the Guide for Counseling Women Who Smoke continued to be some of the most frequent NC DPH web hits. The 5 A's are a best practice model recommended in clinical practice. The WHB has partnered with Northwest AHEC to update the online training, "Counseling for Change." This program links the Guide for Counseling Women Who Smoke and the Counseling From the Heart DVD and is available free without continuing education credit.

The Women and Tobacco Coalition for Health (WATCH) continued to keep tobacco use at the forefront of the women's health agenda.

c. Plan for the Coming Year

NCHSF will continue to expand the initiatives from the previous year. NCHSF will revise, reprint, and distribute publications that address smoking cessation and the benefits to mom and baby for communities and trainings. Innovations to better empower existing programs/initiatives and

community based groups will be the primary goal. Maximizing efforts to promote website and CARE-LINE usage will continue to be the goal.

Healthy Beginnings will continue to have the elimination of use and exposure of tobacco to pregnant women and their children as a focus area. In the RFA that will be implemented in FY11, all programs will continue to have this as a focus area, providing both group and individual support to eliminate the use and exposure of tobacco to both participants and their children.

Due to budget cuts in October and November 2009, the Perinatal Outreach Coordination Program was discontinued, leaving a big gap in service provision. The focus of this program, which was in existence for about 30 years, was on identifying needs and providing the needed educational support to enhance the knowledge, attitudes, and skills of healthcare providers serving women of childbearing age, infants through the first year of life, and their families. The twelve outreach coordinators ensured that the most up-to-date "best practice" standards of care educational and clinical techniques were disseminated to all segments of the healthcare community in order to maintain a high level of consistency in clinical practice and referral standards. Tobacco cessation efforts are just one of many areas in which the loss of this program will be felt. During FY09, the outreach coordinators reached 9,241 healthcare providers through educational programs (39%) and consultative services (61%). The POCs were housed at area health education centers, universities, and tertiary centers throughout North Carolina.

In the coming year, the WHB will continue to work to incorporate tobacco cessation training into perinatal and women's health programs and services and will work on developing webinars to provide additional support to healthcare providers in counseling women.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6
Annual Indicator	7.3	6.5	6.8	6.1	6.5
Numerator	43	39	42	39	44
Denominator	592645	602355	621709	638873	678263
Data Source				NC Vital Records. State Demographer Pop Estimates	NC Vital Records. State Demographer Pop Estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or				Final	Final

Final?					
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	6	5.5	5.5	5.5	5.5

Notes - 2009
Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

FY year data are actually the prior calendar year, e.g. FY09 is really CY08.

Notes - 2008
Data source for the numerator is NC vital records obtained through the NC Data Query System for Leading Causes of Death on the NC State Center for Health Statistics (SCHS) website. The source for the denominator is the State Demographer's Population Estimates obtained through the SCHS query system on the SCHS website.

FY year data are actually the prior calendar year, e.g. FY08 is really CY07.

Notes - 2007
FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

a. Last Year's Accomplishments
In September 2008, North Carolina was awarded the Garrett Lee Smith grant for $1.3 million dollars over 3 years. The grant is managed by the Injury and Violence Prevention Branch (IVPB), who works with a State Grant Team comprised of some Youth Suicide Prevention Task Force (YSPTF) members. For the first grant year, IVPB contracted with the Mental Health Association (MHA) in NC (a founding member of the YSPTF) to develop the communication campaign and coordinate training to increase the number of certified suicide prevention trainers. UNC-Chapel Hill's Injury Prevention Research Center was contracted to do local evaluation of the gatekeeper trainings.

The trainings produced 23 new trainers of suicide prevention programs. These trainers are able to provide a two-day Applied Suicide Intervention Skills Training and/or a half-day safeTALK workshop.

Originally an RFA was written to award suicide prevention funds in 2009-10 to state school health centers which serve middle or high school students. Cherokee County Schools Hiwassee Dam Health Center was the sole recipient of a grant to provide a comprehensive suicide prevention program in their schools. Because the RFA required curriculum changes that can only be accomplished by DPI, only one application was received. The Grant Team developed another approach to provide gatekeeper training to school staff. The Child and Family Support Teams and school health centers were invited to participate in regional suicide prevention gatekeeper training in Project Year 2 of the grant (September 2009-September 2010). The North Carolina Comprehensive School Health Training Center (NCCSHTC) will organize and provide the trainings under a contractual agreement.

Eight youth focus groups were convened to ascertain their media habits and preferences. They were asked about their perceptions of suicide and where they would seek help for themselves or others. Their feedback was used to develop the draft of a youth oriented web site and to identify potential promotional materials.

Members of the YSPTF and the Triangle Consortium for Suicide Prevention (TCSP) participated in the third annual "Walk to Save a Life," raising almost $13,000 for local community efforts.

Grassroots organizations in NC have asked the TCSP for technical assistance to form their own local consortiums. TCSP has been offered training assistance from the national Suicide Prevention Resource Center.

The chairperson of the YSPTF presented another workshop about depression/suicide prevention to three Area L AHEC primary care and hospital physicians and produced a podcast. The MHA in NC continues to provide suicide prevention training per requests, including a presentation to the NCIOM.

In 2007, more than 70% of teens committing suicide used a gun, with a parent's gun being used about half of the time. Working together with Safe Kids, the NRA, the NC Coalition Against Gun Violence, and other stakeholders, the CFTF helped create a gun safety brochure designed for parents. Tens of thousands of brochures have been distributed through Safe Kids partners and the document is also available on-line.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. C&Y Staff serve on the North Carolina Youth Suicide Prevention Task Force (YSPTF) and participate in its activities.				X
2. The CFTF advocates at the legislative level for recommendations made by the YSPTF.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through Garrett Lee Smith grant funds, Child and Family Support Teams and school based/linked health centers were offered suicide intervention training. The NCCSHTC organized eight regional Applied Suicide Intervention Skills Training (ASIST) workshops, with 199 school and school related personnel completing it. A half-day suicide prevention program will be provided to approximately 250 people during 12 regional workshops in 2010. All training participants will take a pre and post test to measure changes in knowledge and beliefs. Recipients of the ASIST workshops will be contacted by the grant's evaluators for follow-up surveys within three months. Additionally, individuals who take the training are to report non-identifying information about students they deem at-risk. Sixteen students have been identified as at-risk of suicidal behavior thus far.

The NCCSHTC will also receive training in a school based suicide prevention curriculum that can be provided in the classroom. This curriculum will be taught to Department of Juvenile Justice health education teachers and school health and physical education teachers.

Work continues to develop a youth oriented suicide prevention web site that will serve as a support and information resource.

The CFTF has recommended that the state restore the third shift of the CARE-LINE, which recently became the roll-over number for the National Suicide Prevention Line.

c. Plan for the Coming Year
Due to the response from schools regarding gatekeeper training, additional workshops will be offered next year to increase the number of school personnel and youth service providers who are able to identify, intervene, and refer students at risk.

One of the mandates of the Garrett Lee Smith grant is to provide a percentage of funds to institutes of higher learning. Gatekeeper training will be provided to the state's community college adult basic education programs which serve a high percentage of young adults. These students are either needing basic skills training and/or pursuing their General Equivalency Diplomas. These workshops will be held regionally.

The grant's local evaluators will send a follow-up survey to staff who received ASIST training last year and compare tests results over time: before the training, immediately after the training, three months after the training and one year after the training.

Cherokee County's school health center will receive funding for a second year and continue gatekeeper training and suicide prevention classroom curriculum.

Beyond the scope of the suicide prevention grant, members of the Triangle Consortium for Suicide Prevention have scheduled their fifth annual suicide awareness walk in November 2010. At the fourth walk held in November 2009, there were approximately 350 walkers who raised close to $24,000 for local suicide prevention activities.

The CFTF has focused on the issue of asphyxiation in teens and will continue to do so. Current data make it challenging to determine if deaths are suicides or tragic accidents following recreational asphyxia. CFTF is tracking training efforts, such as those recently conducted by the CFPTs, to inform professionals about the warning signs and working with stakeholders, such as DPI, to determine strategies to promote healthy risk-taking - without glamorizing it or advertising dangerous behaviors.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	83	83	83	83
Annual Indicator	79.2	79.9	78.2	78.3	78.4
Numerator	1542	1541	1559	1595	1512
Denominator	1946	1929	1993	2036	1928
Data Source				NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	83	83	83	83	83

Notes - 2009
The data source is NC vital records as reported in the 2008 North Carolina Infant Mortality Report, Table 10, Risk Factors and Characteristics for North Carolina Resident Live Births found on the NC State Center for Health Statistics website.

Notes - 2008
The data source is NC vital records as reported in the 2007 North Carolina Infant Mortality Report, Table 10, Risk Factors and Characteristics for North Carolina Resident Live Births found on the NC State Center for Health Statistics website.

Notes - 2007
These data include deliveries at 12 facilities originally designated for high-risk deliveries and neonates back in the 1980s. There are other hospitals within the state with NICUs whose deliveries are not included in this count.

FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

a. Last Year's Accomplishments
The High Risk Maternity Clinic Program provided risk-appropriate care for more than 3,200 women in North Carolina in 2009 at 11 High Risk Maternity Clinics. These women with medically high-risk pregnancies are assessed for medical, nutritional, and psychosocial needs, and a care plan is developed to help them through the pregnancy. Prepregnancy BMIs are collected and special attention paid to the mother's nutritional condition in order to reduce low weight births. Obese women and those with other medical risks for low weight births receive nutrition counseling and classes to improve the weight of the infant. Delivery plans include matching them to a tertiary care center for the potential high risk needs of their infant.

The POCs continued to educate providers on the Neonatal Bed Locator Service and other issues of importance regarding very low birth weight infants born in tertiary centers. During FY09, over 9,241 health care and human service providers from across the state received training through this program. Needs assessments were conducted to determine clinical educational needs. From these assessments, 281 formal training sessions and 448 consultations or technical assistance support services were completed, totaling 2,143 hours of service.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue the High Risk Maternity Clinic Program.	X			
2. Continual review of data to assess sites more likely to keep low birthweight babies.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The High Risk Maternity Clinic Program is funding 10 High Risk Maternity Clinics in LHDs and one tertiary care center in FY10. These women are the highest risk for low weight births and poor

birth outcomes. A projected 3,500 women will be served. A webinar was held in February 2010 to discuss changes in program requirements and discuss emerging issues in High Risk Maternity Clinics in NC. With the economic downturn, LHD high risk maternity clinics report that they are seeing more demand than ever, but with fewer resources available to help cover the growing need.

The POC program and the Neonatal Bed Locator Service were terminated in November 2009 due to the state's budget crisis. One POC program goal for FY10 was to focus on resuscitation and stabilization as a statewide quality improvement issue. During the period June to October 2009, 40 Resuscitation and Stabilization services were provided. The POCs had begun the initial assessment of resuscitation and stabilization services in non-tertiary delivering hospitals and had garnered commitments from local staff to assist in developing a plan to eliminate variations in care that contribute to infant morbidity and mortality during neonatal resuscitation and stabilization events. During May 2008 to June 2009, approximately 800 providers were trained through 66 formal neonatal resuscitation program training and consultative services.

c. Plan for the Coming Year

In FY11, the High Risk Maternity Clinic Program will fund 10 High Risk Maternity Clinics in LHDs. The High Risk Maternity Clinic Program will continue to focus on providing high quality maternal care, medical and preventive care for the perinatal period, and wrap-around services that enhance the chances of fewer low-weight babies. A projected 3,000 women will be served.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	87	87	87	87	87
Annual Indicator	83.3	82.7	81.9	80.9	82.0
Numerator	99822	101716	104528	105849	107183
Denominator	119773	123040	127646	130886	130758
Data Source				NC Vital Records - Birth Certificates	NC Vital Records - Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	87	87	87	87	87

Notes - 2008

The data source is NC vital records as reported in the 2007 North Carolina Infant Mortality Report, Table 10, Risk Factors and Characteristics for North Carolina Resident Live Births found on the NC State Center for Health Statistics website.

Notes - 2007
FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

a. Last Year's Accomplishments
The First Step Campaign continued to promote the NC Family Health Resource Line, the 1-800 MCH hotline, as a vital source for information and referrals. The campaign encourages women to seek early and continuous prenatal care services. First Step campaign activities specifically focused on African American, American Indian, and Latino communities in an effort to address North Carolina's perinatal health disparities. Three focus groups discussing pregnancy intendedness gave qualitative data to inform the state about knowledge, beliefs, practices and healthcare access related to improving the health of minority families. The New Parent/First-time Motherhood initiative focused on creating & facilitating community-led trainings promoting optimal preconception health and wellness. Various print, electronic, and broadcast media targeting families within childbearing age were created supporting the importance of optimal health before, during, and in-between pregnancies.

The Baby Love Maternity Care Coordination Program (MCCP) nurse and social worker case managers provided prenatal case management services to low-income women statewide, as early in pregnancy as possible, and continuing services through the end of the 60 day postpartum period. In SFY09, 18,000 Medicaid-eligible women who had a live birth received MCC case management services during their pregnancies, reaching 32% of the eligible population. Twenty-nine of North Carolina's 100 counties also complemented MCC services with Maternal Outreach Worker services, providing direct support from a paraprofessional in the community setting.

MCCP case managers focus on ensuring that women receive early and continuous access to prenatal care, as well as postpartum health care and desired family planning methods. They provide assessment and intervention for a broad range of psychosocial factors impacting maternal and infant health including: health insurance coverage, access to prenatal care, access to a medical home for their family, family planning, need for interpreter services, social support system, transportation, employment, school enrollment, child care, financial assistance, nutritional counseling, food assistance, breastfeeding information and support, parenting information, adequate and safe housing, smoking cessation, substance abuse, mental health, domestic violence, and sexual abuse.

In FY09, Healthy Beginnings had 13 projects serving 507 minority women and their families. In FY09 there were 240 babies born to the program. Local Healthy Beginnings programs provide extensive outreach and support to families to assist with early and continuous prenatal care. They also focus on breastfeeding initiation and support, environmental tobacco reduction and elimination, folic acid consumption, interconceptional care, and Sudden Infant Death Syndrome education. Healthy Beginnings also continued to offer wrap-around services (education, transportation, group counseling, housing, etc.) to support mothers and young families as they begin their journeys into parenthood.

The TIMR program had six projects serving 971 women and their families. TIMR sites provide community education, outreach, and awareness about maternal and child health issues.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maternity Care Coordination and Maternal Outreach Worker programs ongoing.		X		
2. Re-application process for Minority Infant Mortality Reduction (Healthy Beginning) Projects.				X

3. Continued outreach through Baby Love Plus with a focus on perinatal women's health.		X		
4. Work with Sickle Cell Program to educate families of childbearing age on perinatal health issues.				X
5. 10-county pilot project with MCCs.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY10, state funds for the NC Family Health Resource Line were eliminated. The calls were then directed to the state's toll free line, CARE-LINE. The WHB continues to promote the CARE-LINE as the new resource for information and referrals. First Step campaign activities continue. Through federal grant funding, NCHSF is facilitating community-based trainings and distributing existing toolkits for community use on topics such as women's health, pregnancy, and reproductive life planning. Over 350,000 pieces of educational materials were printed.

MCCP services continue to be available to Medicaid-eligible women in all 100 counties. The data collection system implemented in FY08 continues to be in use and is integrated into the implementation of the new HIS that is rolling out statewide in FY10 and FY11. Due to a legislative mandate, program staff members have been researching alternative models of prenatal case management services to support a statewide effort to consolidate all Medicaid-reimbursed case management services across multiple target populations.

Between Healthy Beginnings and TIMR, there are 20 projects in 17 counties in the last year of this funding cycle. An RFA was released for the 2010-13 funding cycle, and 12 grants were awarded among the 26 applicants. TIMR funding was combined with Healthy Beginnings to better address the disparity that continues to be present in infant mortality in North Carolina.

c. Plan for the Coming Year

The NCHSF will continue to promote ways to improve the health of women of childbearing age and their families by the promotion of the CARE-LINE information and referral service, Foundation & Branch websites, and First Step campaign activities focusing on African-American and American Indian communities and outreach to Latinos. Building on past successful campaign activities, New Parent initiative, and pregnancy intendedness findings, NCHSF will begin collaborating with existing Healthy Beginnings and Baby Love Plus sites (targeting 75 staff) to offer trainings regarding preconceptional and interconceptional care. Using findings from the Latino focus groups and materials developed in the previous year, 45 bilingual staff and outreach workers will be trained on how to effectively use new Latino Family Planning materials.

Change is anticipated for the MCCP services in FY11, with the statewide consolidation of Medicaid case management services. A draft policy has been completed, but is still under review. The proposal includes the addition of entrance criteria for pregnant women to establish risk status meriting the provision of prenatal case management services. As a component of the case management consolidation process, plans are being developed to improve the collaboration between the current Community Care of North Carolina regional networks to more effectively link the obstetrical provider community to prenatal case management services across the state.

Participation with the state universities on research to identify and treat depression is being done. Current plans to offer additional education training to Health Behavior and Intervention counselors in partnership with UNC-Chapel Hill are being considered.

D. State Performance Measures

State Performance Measure 1: *Number of children affected in substantiated reports of abuse and/or neglect as compared with previous years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	27000	27000	24000	14000	12000
Annual Indicator	26670	24597	14744	12312	11171
Numerator					
Denominator					
Data Source				NC DSS CPS Central Registr	NC DSS CPS Central Registr
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	11500	11000	10500	10000	

Notes - 2009
Data retreived March 17, 2009 from the University of North Carolina at Chapel Hill Jordan Institute for Families website. URL: http://ssw.unc.edu/ma/

North Carolina has implemented the Multiple Response System (MRS) statewide. MRS is an effort to reform the entire continuum of child welfare in North Carolina- from intake through placement services. The goal of MRS is to bring services and supports more quickly to families in need, called “frontloading”. Greater frontloading of services reduces the probability that a child would come back into the system within 6 months following an initial assessment finding services needed or a substantiation of abuse or neglect. In 2007 the recurrence of maltreatment did begin to decline by 27% (5.5% in SFY 2006-2007 as compared to 7.5% in 2001-2002).

MRS has changed many data definitions and therefore trend data on assessments and substantiations are not available. MRS allows a two pronged approach to CPS involvement: The Family Assessment Track and the Investigative Track. While the Investigative track is the “traditional approach”, which would lead to the unsubstantiation or substantiation of a case, the Family Assessment track does not. With the Family Assessment Track, families are found “in need of services”, “services recommended”, or “no services recommended”. In February 2006, the NC Division of Social Services added a new finding for Family Assessments, "Services Provided, No longer Needed." This finding indicates that the safety of a child and future risk of harm are no longer issues because the agency has been successful in frontloading necessary services during the family assessment and therefore the case was neither substantiated or “Services Needed”. As the Family Assessment Track of MRS can address neglect and dependency, some of the “Services Needed” reflects dependency allegations. (NC Division of Social Services, 2007).

Notes - 2008
North Carolina has implemented the Multiple Response System (MRS) statewide. MRS is an effort to reform the entire continuum of child welfare in North Carolina- from intake through

placement services. The goal of MRS is to bring services and supports more quickly to families in need, called “frontloading”. Greater frontloading of services reduces the probability that a child would come back into the system within 6 months following an initial assessment finding services needed or a substantiation of abuse or neglect. In 2007 the recurrence of maltreatment did begin to decline by 27% (5.5% in SFY 2006-2007 as compared to 7.5% in 2001-2002).

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Notes - 2007

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a. Last Year's Accomplishments

The Parent Education Consultant position has been reclassified as the Evidence-Based Family Strengthening Program Coordinator but the position is unfilled and frozen due to state hiring prohibitions. The Executive Director of the Child Maltreatment Prevention Leadership Team (CMPLT) has, in the interim, taken the lead on parenting programs. An RFA was issued to LHDs for the following evidence-based programs (EBP): The Incredible Years (IY) 3-6 and 6-12 and The Strengthening Families Programs (SFP) 6-11, 10-14, and 12-16. Awards will be made to 15 LHDs. C&Y Branch staff served on the Fatherhood Advisory Council and continued work with the NC Parenting Education Network as well as the Alliance for Evidence-Based Family Strengthening Programs (The Alliance). Through The Alliance, the C&Y Branch continues to build support to communities for implementation of EBPs with model fidelity. DPH remains the lead state agency in prevention of child maltreatment via the CMPLT located in the WCHS. The CMPLT emphasis is on a number of strategies: the implementation of evidence-based practices;

influencing social norms to support healthy parenting and strong families; enhancement of service delivery to families; increased/shifted funding for child maltreatment prevention services; and building the infrastructure within DPH to lead child maltreatment prevention (CMP). The CMPLT implemented and/or completed the following recommendations in 2009:
-Increased requirements among state level agencies in the use of EBPs as a funding criterion and the continuation of The Alliance;
- Continuation of implementation of the Nurse Family Partnership (NFP);
- Two additional counties received funding for NFP in 2009 through a public-private funding initiative (DPH, the Duke Endowment [TDE], Kate B. Reynolds Charitable Trust, and the Blue Cross-Blue Shield Foundation), bringing the total number of counties with NFP in their service continuum to 10;
-Framing Early Childhood for Public Understanding and Support Initiative - Through funding provided by DPH and TDE, 15 public and private organizations completed a 6-month Strategic Frame Analysis study circle facilitated by the FrameWorks Institute building their communications capacity based on research on early childhood development;
-The Period of PURPLE Crying Project was taken state-wide. The project aims to prevent child fatalities and child maltreatment via a hospital and health care provider-based parent education program, a video and a booklet that parents can share with other caregivers and a public awareness campaign. This is a joint project with the UNC-Chapel Hill Injury Prevention Research Center, National Center on Shaken Baby Syndrome, and Center for Child and Family Health;
-The Early Childhood Comprehensive System (ECCS) Initiative continued to facilitate a collaborative decision making and action oriented group in the early childhood system and worked with Georgetown's National Technical Assistance Center for Children's Mental Health to develop a plan for a public health approach to promoting social emotional development;
- A DPH team (members from WCHS, IVPB, and the OCME participated in a nine-month Preventing Violence through Education, Networking and Technical Assistance (PREVENT) Institute with the aim of building DPH infrastructure to lead CMP in NC. Work products include: an internal environmental scan of DPH, a survey to measure base-line attitudes of public health employees regarding CMP, and a five year plan;
- The WCHS of DPH applied for and received a LAUNCH grant through SAMHSA that will be implemented in Guilford County;
- The CFPT continued to provide Safe Surrender Workshops and educational materials to community partners as requested. About a quarter of counties have done work in this area; for example, one county erected a billboard and another created a brochure. The CMPLT, CFTF, and ECCS Initiative are working closely with this project to ensure collaborative, non-duplicative efforts; and
- The CMPLT and IVPB applied for several unsuccessful funding opportunities to develop a child maltreatment morbidity surveillance system.

The Director of the Child Fatality Task Force resigned in 01/09. A new Director was hired in 12/09. The CFTF and CMPLT EDs are members of the NCPS Committee on Child Abuse and Neglect and the Child Fatality Prevention Team (CFPT). They also both serve on the NC System of Care Collaborative and the Program Improvement Plan Committee for NC-DSS.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued implementation of the Adolescent Parenting Program Projects.		X		
2. Continue training professionals and public awareness activities for the Infant Homicide Prevention Act.			X	
3. Assist with implementation of Task Force on Child Maltreatment Recommendations.				X
4. Expand the role of the Parenting Program Manager to be a focal point for prevention of CAN activities and expand the				X

inclusion of fathers in planning, education and training.				
5. Continue collaboration with NC Parenting Education Network.				X
6. Continue support of the NC Fatherhood Development Advisory Council.				X
7. Assist with the implementation of the Nurse Family Partnership.				X
8. Continue the development of the Every Child Succeeds Facilitation Team.				X
9.				
10.				

b. Current Activities

DPH continues internal work for leadership in CMP. This includes a survey to obtain baseline data on attitudes regarding CMP; building relationships between WCHS, IVPB, and the OCME; participating in a visit for the Public Health Leadership Initiative; and building capacity for state leadership in NFP. The C & Y Branch awarded 15 grants to LHDs to implement IY or SFP in January 2010 and worked with The Alliance to ensure effective implementation. WCHS is working on building capacity to provide support for the SFP. The CMPLT is working on the following: a collaborative network of public and private funders who support the replication of specific EBPs for children and families; securing funding for the implementation of a mortality surveillance system; and development of DPH infrastructure which leads CMP activities. Ongoing funding was awarded for the ECCS initiative. Outcome goals include continued development of state-level leadership for decision making and action in the early childhood system. The CFTF and the CMPLT work cooperatively to assess services for maternal depression including increased Medicaid coverage and studying the feasibility of a centralized state toll-free number reporting system. Governor Purdue proclaimed January 2010 the "Period of PURPLE Crying Month." The Period of PURPLE Crying program received a national award from the National Center on Shaken Baby Syndrome.

c. Plan for the Coming Year

Capacity development for child maltreatment prevention leadership and the ECCS Initiative will continue. Through ECCS, WCHS will participate in the development of the state's early childhood council. C &Y Branch will apply for funding from TDE to build the needed infrastructure to support NFPs at the state level. This will include a state nurse consultant and state coordinator for NFP. Through the new collaborative infrastructure (including IVPB and OCME), work toward the implementation of the recommendations in the state's plan to prevent child maltreatment, the New Directions report, as well as work toward the goals of the CFTF, the ECCS initiative, the IVPB, and the CFPT will continue. Work on the New Directions recommendations that began in FY10 will continue, with the addition of the following priorities and activities: the use of shared indicators among multiple state agencies; a plan for supporting a strong service delivery system continuum within local communities; coordinated efforts within WCHS and the IVPB (including increased population-based sexual abuse prevention programs); and development of a statewide strategic plan to support families and children.

WCHS will also continue the work with collaborative partners in the area of domestic violence and CMP, the expansion of universal/selective CMP efforts, and increased training/awareness on child abuse and neglect reporting laws (focus on health professionals and educators), including the feasibility of a centralized reporting system. Prevent Child Abuse is working with a team of public policy graduate students on the issue of reporting child abuse. The CFTF ED is participating in this process and CFTF members will use the results of the study to inform recommendations to improve the reporting of child abuse throughout NC.

The CFPT will provide Safe Surrender Workshops and educational materials to community partners. Safe Surrender will continue to be a priority.

C & Y will continue implementation of Project LAUNCH and coordinate activities with CMP, ECCS, CFTF, and evidence-based parenting programs. Via LAUNCH, the WCHS will explore the implementation of Triple P - Positive Parenting Programs(R). Project LAUNCH will inform service delivery throughout NC.

Ongoing IY and SFP funding for 15 LHDs to build capacity and implement EBP with fidelity will be supported. The upcoming RFA may include implementation of Triple P in the funding menu.

WCHS will continue work toward movement from the "child maltreatment prevention frame" to the CDC frame of "supporting safe, stable, and nurturing relationships" and the frame of "promoting healthy brain development" in an effort to build more collaborative partners and gain broader support for family strengthening programs. WCHS will work with the DPH social marketing program to produce materials.

State Performance Measure 2: *The number of children in the State less than three years old enrolled in early intervention services to reduce the effects of developmental delay, emotional disturbance, or chronic illness.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		13673	15040	15500	15700
Annual Indicator	12436	13673	15048	15869	17606
Numerator					
Denominator					
Data Source				EI Branch CECAS	EI Branch CECAS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	16000	16000	16000	16000	

Notes - 2009
Manual indicator (count) is used in this state performance measure.

Notes - 2008
Manual indicator (count) is used in this state performance measure.

Notes - 2007
Manual indicator (count) is used in this state performance measure.

a. Last Year's Accomplishments
Continued work on quality improvement measures for the State Performance Plan occurred. During this fiscal year, the quality improvement methods included child record reviews, data verification visits, and focused technical assistance.
The number of infants and toddlers referred to and enrolled in the program continues to increase. The program has an annual headcount measure, performed on December 1 of each year. On December 1, 2008, the number of infants and toddlers enrolled in the program was 9,290 whereas the number of infants and toddlers enrolled on December 1, 2009 was 9971. These data reflect a 7% increase, and the program continues to collect headcount data on a monthly basis.

Service resource needs are projected per the monthly headcount data, as this represents the number of infants and toddlers receiving services the first day of each month. New allocations ($12M) gained during previous fiscal years were reduced by $7.5M due to revenue projections to the state. Increases in reimbursement to the program through

services provided by CDSA staff to infants and toddlers who are Medicaid-eligible and carry forward of federal grant dollars was used to offset reductions where possible. American Recovery and Reinvestment Act (ARRA) funding was granted as of February 2009 and planning for use of the funds in 2009-2010 occurred.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continued implementation of state level monitoring system.				X
2. Collection of referral data on a monthly basis.				X
3. Increase in number of enrolled children to 16,000 in 2009-2010.	X			
4. Development and implementation of State Performance Plan (SPP).				X
5. Public reporting on all data from SPP at local and state levels.				X
6. Continued examination of and improvement in efficiency and effectiveness.				X
7.				
8.				
9.				
10.				

b. Current Activities

Continued work on quality improvement measures occurred. Performance targets for child and family outcomes measures were developed for the Annual Performance Report. Quality improvement methods include child record reviews, data verification visits, focused technical assistance, and integration of fiscal monitoring verification and staff certification verification into overall general supervision methods. A new data system (Health Information System [HIS]) including child-specific and billing data will be implemented in June 2010.

The Early Intervention program continues to experience increases in the number of infants and toddlers enrolled. Developmental screening in multiple areas (e.g., general developmental screening, autism screening, and socio-emotional screening), increased awareness for families and physicians regarding developmental needs, and public awareness efforts through local agencies affected the number of children enrolled prior to their first birthday.

The program realigned resources and explored policy changes to adjust to budget reductions. Use of federal ARRA dollars is being used for one time enhancements to the program and for ongoing service delivery needs. Maintenance of effort and non-supplantation under the program's federal legislation continue, and ARRA requirements on reporting are being met.

c. Plan for the Coming Year

Continued work on quality improvement regarding expected federal regulations changes will occur. Performance targets for child and family outcomes measures will be reported. Quality improvement methods will include child record reviews, data verification visits, focused technical assistance, integration of fiscal monitoring verification and staff certification. HIS will be phased in statewide during 2010-2011.

The Early Intervention program expects continued increases in the number of infants and toddlers enrolled. Developmental screening in multiple areas (e.g., general developmental screening, autism screening, socio-emotional screening) will continue to increase awareness for families and

physicians regarding developmental needs.

The program will continue to realign resources and explore policy changes to adjust to budget reductions and assure sustainability of efforts begun under federal ARRA dollars. Maintenance of effort and non-supplantation under the program's federal legislation will continue, and ARRA requirements on reporting will continue. ARRA funding is available through September 30, 2011.

State Performance Measure 3: *Percent of children 2-18 who are overweight. Overweight is defined as a body mass index (BMI) greater than or equal to the 95th percentile for gender and age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		15	14	13	12
Annual Indicator	17.0	16.7	17.4	17.3	17.5
Numerator	17394	19151	20062	20863	19295
Denominator	102480	114970	115394	120472	110406
Data Source				NC-NPASS	NC-NPASS
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	10	10	10	10	

Notes - 2009
The data source is NC Nutrition and Physical Activity Surveillance System (NC-NPASS) which includes data from children who participate in Child Health and WIC in local health departments and children in School Based/School Linked Health Centers.

FY year data are actually the prior calendar year, e.g. FY09 is really CY08.

Notes - 2008
The data source is NC Nutrition and Physical Activity Surveillance System (NC-NPASS) which includes data from children who participate in Child Health and WIC in local health departments and children in School Based/School Linked Health Centers.

FY year data are actually the prior calendar year, e.g. FY08 is really CY07.

Notes - 2007
FY year data are actually the prior calendar year, e.g. FY07 is really CY06.

a. Last Year's Accomplishments
Since this state performance measure was created, the CDC has changed the definition of childhood overweight to describe a BMI between the 85th and 94th percentile, and obese is defined as equal to or greater than the 95th percentile. Thus, the data in this measure are really for the obese category of children. Data for this measure, which include only children seen in North Carolina public health sponsored WIC and Child Health Clinics and some School Based Health Centers have remained at about 17% for the past five years, with the 2008 data giving a rate of 17.8%. In 2008, an additional 16.4% of children measured were overweight.

During FY09, activities undertaken by the C&Y Branch and NSB to promote healthy weights among children 2-18 years of age included:
-continuing the collaboration with DPI on implementation of USDA-required local wellness policies

and school nutrition standards;
-promoting the toolkits to support implementation of local wellness policy in schools, provide nutrition education, and to promote school meals as the healthy, low-cost choice;
-providing training on implementing local wellness policy to school systems and community partners;
-facilitating execution of the N.C. School Health Nutritionists Network action plan;
-drafting policy for an Adolescent Package of Services for reimbursement by Medicaid;
-providing Train the Trainer workshops for "Smart Options" certification training for Child Nutrition professionals;
-providing nutrition education training and resources for the 32 schools participating with the USDA Fresh Fruit and Vegetable Program (FFVP);
-providing training on the "Food for Thought-Making the Connection" toolkit;
-providing continuous nutrition consultation and quality improvement to the C&Y Branch School Health Unit, SBSLHCs, Regional School Nurses; and the School-Based Child and Family Support Initiative Program; and
-presenting a workshop on Farm to School Network initiatives to state Child Nutrition Service Directors at their annual conference; and
-continuing the implementation of the Pediatric Nutrition Course (PNC) by piloting Module 2: Basic Nutrition. PNC is an online, self-paced course co-sponsored by the NSB and the NCIPH. The goal of the PNC is to provide public health nutritionists working in local health agencies with the knowledge and skills needed to improve the nutritional health of the pediatric population.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Enhancement of Nutrition and Physical Activity Surveillance System (NC-NPASS).				X
2. Education of health care professionals/staff training.				X
3. Education of children and their parents/caretakers.		X		
4. Continuation and expansion of Nutrition and Physical Activity Self Assessment for Child Care.				X
5. Implement WIC program policies supportive of dietary change.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Continuing activities planned by the C&Y Branch and the NSB for FY10 include:
-collaborating with DPI on projects;
-offering Train-the-Trainer workshops for "Smart Options" certification training for Child Nutrition professionals;
-evaluating the "Smart Options" training;
-monitoring nutrition services as provided via SBSLHCs funded by the state; and
-assisting with the execution of the NC School Health Nutritionists Network action plan for school health nutritionists through monthly meetings with strategic planning committee; webinar presentations covering key issues of student health and nutrition; train-the-trainers workshops; provision of training and resources for the 62 schools expected to participate in the USDA FFVP; and development and implementation of the on-line PNC.

New activities planned by the NSB for FY10 include development of the following items:
-a nutrition education bulletin board toolkit for schools,

-a staff wellness toolkit for Child Nutrition professionals,
-a school breakfast promotional toolkit, and
-a school garden brochure.

In addition, the C&Y Branch will
-plan several workshops with DMA (including a WebEx Series) related to the "National Recommendations for Preventive Adolescent Health Care for Public/Private Sector Providers;"
-present workshop on Farm to School Network initiatives to state dietitians; and
-collaborate with the PAN Branch's Move More After-School Collaborative.

c. Plan for the Coming Year
Continuing activities planned by the C&Y Branch and the NSB for FY11 to promote healthy weights among children 2-18 years of age include:
-collaborating with DPI on projects including implementation of local wellness policies and school nutrition standards and development of and training on a modified diets toolkit for schools;
-offering Train-the-Trainer workshops for "Smart Options" certification training for Child Nutrition professionals;
-evaluating "Smart Options" certification training for Child Nutrition professionals;
-offering training on and promotion of a staff wellness toolkit for Child Nutrition professionals;
-developing, distributing, offering training, and promoting a school breakfast promotional toolkit;,
-developing a school garden toolkit;
-continuing to provide nutrition consultation and quality improvement to the C&Y Branch, School Health Unit, SLSBHCs, Regional School Nurses; School Based Child and Family Support Initiative Program;
-presenting a minimum of 6 webinars with continuing education credits for school health nutrition professionals via the NC School Health Nutrition Network; and
-collaborating with the national and regional Farm to School Network to promote farm field trips, farm-based nutrition education, and school gardens; to increase awareness of USDA Fresh Fruit and Vegetable Program; and to support more locally grown food served in the school cafeteria.

State Performance Measure 5: *The percent of women responding to the Pregnancy Risk Assessment Monitoring System (PRAMS) survey that they either wanted to be pregnant later or not then or at any time in the future.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40	39	39	38	38
Annual Indicator	44	44.4	47.6	39.8	43.9
Numerator					
Denominator					
Data Source				Pregnancy Risk Assessment Monitoring System	Pregnancy Risk Assessment Monitoring System
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38	38	38	38	

Notes - 2009
Data are for CY08. PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

Notes - 2008
Data are for CY07. PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

Notes - 2007
Data are for CY06. PRAMS data are weighted to get the final state percentage, so numerator and denominator data are not available.

a. Last Year's Accomplishments
2008 data from PRAMS show that 43.9% of pregnancies were unintended. This is almost a 4 percentage point increase when compared to CY07 rate of 39.8%, and also equals the 2004-2008 five-year weighted average. The most recent unintendedness rate is also slightly higher than the 2010 objective (43%) in the
Logic Model adopted by the WHB.

The Family Planning and Reproductive Health Unit (FPRHU) of the WHB continues to provide comprehensive family planning services through a network of approximately 140 service sites throughout the state. These sites served 143,225 unduplicated patients in CY09. This number represents a 3.2% increase, or an additional 4,502 patients, compared to the previous year's total of 138,723. Unduplicated patient numbers have increased for the past two consecutive years indicating perhaps a reversal of the declining trend in patient numbers. The implementation of an outreach and marketing initiative designed specifically to increase patients numbers in 26 targeted LHDs which began three years ago has significantly contributed to the increase in patient numbers. During the second year of implementation, 17 of the 26 funded projects met or exceeded their objectives, while the other 9 agencies are projected to meet their respective objectives by the third year of the special initiative project. Collectively, the 17 project sites served an additional 1,372 new patients in CY09.

The FPRHU revised the funding formula for distributing State Women's Health Service Funds that supplement the cost of contraceptives in CY08. The revised formula provides additional incentives for local agencies to promote the use of Long Acting Reversible Contraceptives such as Intrauterine Device (IUD), 3-month hormonal injection, hormonal implant, contraceptive patch, and vaginal ring. Most recent CY09 data from the Family Planning Annual Report (FPAR) show that 41% (44,300) of all women who are contracepting are using the more effective reversible methods compared to 34% in CY08.

The distribution of other methods, such as vaginal rings and contraceptive patches, has remained relatively constant while the numbers of IUD and hormonal implant users continue to increase. However, the number of teens using hormonal injections have declined by a little more than 10%, when compared to CY08 FPAR data

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Full implementation of the 1115(a) demonstration waiver (Medicaid waiver).				X
2. Continuation and expansion of the Hispanic/Latino Outreach Initiatives.		X		
3. Continuation and expansion of special outreach initiatives,		X		

particularly to teen patients.				
4. Continuation of sterilization funding and services.				X
5. Continuation of TPPI, with greater emphasis on programs for Hispanic/Latino youth.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FPRHU is in the fifth year of a 1115(a) Medicaid Demonstration Waiver which extends eligibility for family planning services to women (age 19-55) and men (age 19-60) with incomes =< 185% of the Federal Poverty Level. The FPRHU and DMA are in the process of reapplying for another five-year demonstration period. The major goals of the waiver remain the same: to reduce unintended pregnancies and improve the well being of children and families in NC.

In FY09, the fourth year of waiver implementation, 25,301 patients were served by LHD family planning clinics, an increase of 42% from FY08. The total number of patients served by all approved providers for both new enrollees and continuing clients from year one was 59,395 (51,157 females and 8,238 males), an 11% increase from FY08.

The increase in the Hispanic population in NC continues to be a challenge for local maternal health and family planning clinics. To help meet this challenge, the FPRHU continues to fund and expand the Latino Family Planning Outreach Initiative with $500,000 in special Title X funds for special projects in communities with large Hispanic/Latino populations. In FY09, three new agencies were funded, bringing the total number of projects to seven. The FPRHU is also implementing the specific action steps prescribed for the unit in DPH's Recommendations for Eliminating Health Disparities.

c. Plan for the Coming Year
The FPRHU will continue the implementation of the 1115(a) Medicaid demonstration waiver and the renewal application process. Two objectives of the waiver specifically target reductions in the number of inadequately spaced pregnancies and the number of unintended and unwanted pregnancies among women eligible for Medicaid.

The evaluation component of the Medicaid waiver, implemented in FY07, continues to yield positive results. Measured in terms of budget neutrality, the reduced costs associated with the estimated range of 1,402 to 1,427 averted births offset the costs of the waiver by an estimated $13.6 million. Subsequent data from the evaluation will be carefully analyzed by Unit staff and DMA staff. Results will help shape future activities for the Medicaid waiver, particularly in the renewal application process.

The FPRHU will also reapply for a competitive Special HIV Integration Grant from the Office of Population Affairs. Currently three local agencies receive special funding to increase HIV testing in the family planning clinic setting. The Unit is projecting one additional project site with this grant.

In response to the declining patient census, the FPRHU will continue to implement and evaluate the outreach and marketing initiative in FY11, with an eye towards identifying best practice models that may be replicated in other local health departments, given additional funding.

Regional Consultant staff reorganization due to a number of staff retirements will continue to be

refined, and activities and responsibilities will be redistributed as the Medicaid waiver and other initiatives are implemented. Accountability issues will continue to be a major focus. Specifically, local agency contracts which include program specific process and outcome objectives will be assessed more systematically. In addition, the results of regularly scheduled clinical Quality Assurance Monitoring will be analyzed more carefully to determine their impact on clinical practice, training needs, future policy changes, etc. The emphasis on increasing patient census, particularly teens, will continue. TPPI will continue to expand with the restoration of TANF funds. This is significant in light of the high rates of out-of-wedlock births and recent increases in unintended pregnancy rates among teens.

State Performance Measure 6: *Percent of women of childbearing age taking folic acid regularly.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	50	50	50	50	50
Annual Indicator	47.1	38.5	29.2	38.3	38.3
Numerator					
Denominator					
Data Source				NC BRFSS	NC BRFSS
Is the Data Provisional or Final?				Final	Provisional
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	50	50	50	50	

Notes - 2009
These data are for CY2008 from the BRFSS. Data are only available every other year through BRFSS. As the folic acid questions have changed from prior years, data for 2007 and beyond are not comprable to data from previous years.

Notes - 2008
As the folic acid questions have changed from prior years, data for 2007 and beyond are not comprable to data from previous years.

Notes - 2007
These data are for CY2007 from the BRFSS. As the folic acid questions have changed from prior years, data for 2007 and beyond are not comprable to data from previous years.

a. Last Year's Accomplishments
Data from the NC Behavioral Risk Factor Surveillance System (BRFSS) indicated that in 2001, 42.2% of women of childbearing age (15-44 years) in NC took folic acid regularly. This percentage jumped to 47.1% in 2004, but then decreased to 38.5% in 2006. More recent trend data for this measure are not available as the questions used in the NC BRFSS have changed over the years. Using the new questions, NC BRFSS data for 2007 indicated that only 29.2% of women aged 18 to 44 were currently taking a multivitamin containing folic acid at least 5 times per week. This increased to 38.3% in 2008.

The NC Folic Acid Campaign web site (getfolic.com) was completely redesigned to include preconception health content for consumers and updated information about the importance of daily folic acid consumption for consumers and health care providers. The Spanish-language version of the site launched in September 2009. Twitter, blogs and Web ads directed at women of childbearing age produced a 43% increase in visitors to the web site (74,580 total web site visits in the calendar year). Regional coordinators continued educating health care providers via office presentations and conference presentations, as well as pre-service training programs for

medical assistants and dental hygienists. The health care provider trainings included preconception health language, highlighting folic acid as one of several important preconception health topics providers should discuss with all women of childbearing age. These trainings included the distribution of a new brochure which focused on women ages 25-35. The data from the Latino campaign survey led to changes in media messaging for this population and priority counties to target. Finally, the Office Champion survey results were analyzed and published in the September/October 2009 issue of the NC Medical Journal and showed the program to be effective in influencing health care professional's counseling behavior. The NSB continued efforts through the WIC Program to educate women about the importance of folic acid for women who may become pregnant.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Education of health care professionals via a variety of strategies.				X
2. Education of consumers and reminders to take a multivitamin daily.			X	
3. Mass media and public awareness activities.			X	
4. Distribution of multivitamins with folic acid to low income non-pregnant women.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The NCGA provided funding for the statewide distribution of multivitamins with folic acid to low income non-pregnant women of childbearing potential to help prevent birth defects. DPH and the NC Chapter of the March of Dimes Foundation have formed a partnership to provide the multivitamins through health departments and other safety net providers. The program will include the purchase and distribution of multivitamins, training for local health department and community health center staff, and technical assistance for participating agencies as they set up this program. In addition, the NSB continues education through the WIC Program on the importance of folic acid for women who may become pregnant.

c. Plan for the Coming Year

In FY11 statewide folic acid education in family planning and maternity clinics statewide will continue as will networking with the state chapter of The March of Dimes where folic acid awareness and education in women of child bearing age to prevent birth defects is a priority. The NSB will continue its education efforts through the WIC Program on the importance of folic acid for women who may become pregnant.

State Performance Measure 7: *The ratio of school health nurses to the public school student population.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	**2005**	**2006**	**2007**	**2008**	**2009**

Data					
Annual Performance Objective	1:1500	1300	1200	1200	1150
Annual Indicator	1,593.1	1,571.3	1,340.8	1,225.4	1,206.6
Numerator	1332009	1363695	1386363	1404957	1410497
Denominator	836.1	867.9	1034	1146.5	1169
Data Source				NC Annual School Health Services Report 2007-08	NC Annual School Health Services Report 2008-09
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	1150	1100	1100	1050	

Notes - 2009
As colons aren't allowed in the measure, the number listed in the objectives is the second number of the ratio (1:1225.4, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY06 Students: 1,363,695 School Nurse FTEs: 867.9; ratio 1:1571
FY07 Students: 1,386,363 School Nurse FTEs: 1034; ratio 1:1341
FY08 Students: 1,404,957 School Nurse FTEs: 1146.5; ratio 1:1225.4
FY09 Students: 1,410,497 School Nurse FTEs: 1169.04; ratio 1:1207

Notes - 2008
As colons aren't allowed in the measure, the number listed in the objectives is the second number of the ratio (1:1225.4, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY06 Students: 1,363,695 School Nurse FTEs: 867.9; ratio 1:1571
FY07 Students: 1,386,363 School Nurse FTEs: 1034; ratio 1:1341
FY08 Students: 1,404,957 School Nurse FTEs: 1146.5; ratio 1:1225.4

Notes - 2007
As colons aren't allowed in the measure, the number listed in the objectives is the second number of the ratio (1:1918, etc.), i.e., the number of students per school health nurse.

School health nurse to student ratios were based upon full-time equivalencies of school nurse staff. The number of students and school health nurse FTEs from which the ratios were calculated are as follows:

FY06 Students: 1,363,695 School Nurse FTEs: 867.9; ratio 1:1571
FY07 Students: 1,386,363 School Nurse FTEs: 1034; ratio 1:1341

a. Last Year's Accomplishments
The School Health Unit (SHU) completed the NC Annual School Health Services (NC ASHS) report for school year 2008-09 (SY09) and is in the process of distributing the report to school health stakeholders, including key decision-makers in local and state government, statewide

advocates for school health, and the media. The report will soon be posted on state public health and state education websites. The SHU utilized report information to identify trends in student needs and service delivery models. The report indicated that more than 80% of school nurses in NC hold a bachelor's degree or higher, and more than 50% are nationally certified in school nursing (9 percentage points higher than previous year). An outcome of the review of data was increased collaboration with other providers of health services in the schools including DMA; specialists in chronic health conditions in the pediatric population, including asthma, diabetes, and CYSHCN; and providers of school nutrition services, both in regards to increased nutritional value and provisions for students needing diet modifications.

The introduction of H1N1 Novel Influenza Virus to the state in May 2009 resulted in increased collaboration with schools and the state's Emergency Preparedness staff to provide epidemiological surveillance as well as information and advice regarding prevention and treatment of those with the virus. Work continued on the revision of the state school health program manual, with particular attention to including recommendations regarding communicable disease control and prevention.

The NC ASHS report was again used to support recommendations for increased school nurse positions, and in the summer of 2009, the NC General Assembly allocated money to increase the number of school nurses by 20; however, due to state budget constraints, position allocation was postponed for a year. In SY09, the school nurse to student ratio was recorded as 1:1,207 (average statewide; local ranges are from one per 600 to one per 3,500), reflecting improvement in this measure.

The six regional school nurse consultants (RSNCs), along with the state School Nurse Consultant (SNC), provided training and support to almost all nurses new to school nursing practice with a revised orientation program that took into account travel and budget restrictions. The orientations were delivered in regional locations at smaller venues for a shorter length of time, with some assignments given to the participant's pre and post sessions. Each of the school nurses under the School Nurse Funding Initiative (SNFI), regardless of years of service, developed an individual work plan that addressed the six major directives of the legislation creating those positions. Performance measures from the work activities of the 212 nurses are reflected in the SNFI Annual Report. The Annual Report addressed the overall progress toward meeting outcomes, detailing the activities and strategies utilized in six basic school health service areas.

In addition, the RSNCs continued to work within their regions to promote the development and expansion of school health services. They collaborated with the N.C. School and Community Health Alliance to increase access to school-based or school-linked health care, particularly for underserved adolescents. The RSNCs also collaborated with AHECs and the NC Institute for Public Health to plan, develop, implement and evaluate continuing education activities for school nurses statewide: teleconferences and workshops on School Nurse Case Management, School Nurse Certification Review course, and the Annual School Nurse Conference. The RSNCs provided professional nursing guidance to the school nurses working in the Child and Family Support Team (CFST) program and provided assistance to the NC Diabetes Advisory Council as they navigated a new state reporting requirement for schools regarding enrollment and services to students with diabetes.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Development of program agenda for Annual School Nurse Conference and other continuing education offerings.				X
2. Clinical and administrative consultation, training and technical assistance to school districts, local health departments, and hospitals.				X

3. Collection and analysis of data regarding health needs, resources and program services.				X
4. Development of standards, guidelines and procedures.				X
5. Dissemination of new nursing and school health related information.				X
6. Collaboration with families and at least five other stakeholders in school health outside of the Division, school districts, and health departments.				X
7.				
8.				
9.				
10.				

b. Current Activities

Data supporting the positive impact of school nurses resulted in more local funding of nurses, and a reduced school nurse to student ratio of one per 1,207 students. Case management of CYSHCN by school nurses was a focus of three teleconferences and two workshops in FY10. The state and regional SNCs updated the 300-page N.C. School Health Program Manual and the state SNC partnered with the NC Office of Emergency Medical Services to revise the NC Emergency Guidelines for Schools Manual. The state and regional SNCs are participating in a pilot project to increase utilization of the KHA and enroll 5-year-olds in health insurance. The state and regional SNCs collaborated with the TPPI to allocate local grants to reduce teen pregnancy. The additional positions (13.75) budgeted for the SNFI program by the General Assembly in 2009 were allocated for next fiscal year. The state SNC spoke before the NC Family Council and led discussion on best practice recommendations for school health plans for CYSHCN. The state and regional SNCs maintained collaborative relationships with providers of care to school children through a variety of organizations and methods. The consultants continued to develop, promote, and evaluate continuing education opportunities for school nurses. More than 600 school nurses attended the 26th Annual School Nurse Conference in October 2009. The RSNCs provided technical assistance to the Eastern AHEC to provide a school nurse certification review course.

c. Plan for the Coming Year

The state allotment of funding for 13.75 additional school nurse positions will take effect during FY11. The total number of state funded school nurses will then be 325.75 (225.75 SNFI, 100 CFST). The SNCs will implement a school nurse certification review course in a western NC location in partnership with the Northwest AHEC services. The SNCs will provide increased technical assistance to the nurses working in the SBHCs, in anticipation of an increased role for SBHC in the federal health care overhaul law. They will maintain current assistance to the school nurses working in the high-risk population served by the CFST program as well as to those serving CSHCN in the state's charter and private schools. The state's charter schools will be brought into full participation in the NC ASHS report, and private schools will be drawn into the systematic data collection.

The state and regional SNCs will continue to serve on committees that affect school health, such as the State Advisory for Adolescent Sexual Health and the NC Asthma Alliance, and will review continuing education opportunities. The state SNC will institute a systematic review of the level of satisfaction that recipients of their services perceive they receive as a result of the RSNC activities, consultations, educational sessions, and participation in advisory committees. The SNCs will maintain partnership with the School Health Matrix Team. The 27th Annual School Nurse Conference will be held in October.

The RSNCs will assess the quality indicators for school nurses including the number and percent of school nurses who are nationally certified in school nursing and who hold advanced degrees. School nurses will be asked to gather outcome data on their activities, beginning with

benchmarks during SY10. These data will be included in future NC ASHS reports and the outcomes will be used to identify trends in student needs and service delivery and to support recommendations for improving the student to school nurse ratio. The successful implementation of any legislative action for that goal will be a key activity.

The SNCs will continue work in school nurse case management by assisting the East Carolina University School of Nursing project and making plans for sustainability of this approach Data and evaluation from the first two years of the project show it to be a promising practice.

The revised School Health Program Manual will be distributed via the Internet and DPI may print it as well. The Emergency Guidelines for Schools Manual is in print and will be distributed to each individual school. It is designed to assist school personnel to deliver emergency care for students when the school nurse is not immediately available. The state and regional SNCs will continue to work with the Healthy and Ready to Learn Initiative to increase enrollment of kindergarten students in health insurance by utilizing the KHA as an assessment tool, in partnership with the NCPS and others.

State Performance Measure 8: *Percent of women with live, term births who gain within the Institute of Medicine (IOM) Recommended Weight Gain Ranges.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		34	35	36	37
Annual Indicator	33.6	33.0	32.9	34.0	31.8
Numerator	12429	12227	12959	15642	15835
Denominator	36981	37012	39331	45960	49872
Data Source				NC Pregnancy Nutrition Surveillance System(NCPNSS)	NC Pregnancy Nutrition Surveillance System(NCPNSS)
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	38	38	38	39	

Notes - 2009
Data are based on prior CY (FY09 is really CY08). As per the detail sheet, these data are only available for women receiving WIC services.

Notes - 2008
Data are based on prior CY (FY08 is really CY07). As per the detail sheet, these data are only available for women receiving WIC services.

Notes - 2007
Data are based on prior CY (FY07 is really CY06). As per the detail sheet, these data are only available for women receiving WIC services.

a. Last Year's Accomplishments
NC's Pregnancy Nutrition Surveillance System (PNSS) links data from the WIC program, public maternity clinics, birth certificates, and fetal death certificates. State data for 2008 for this measure show that 33.5% of women had gained within the recommended IOM ranges that were current at that time. This percentage has remained about the same since 2000, thus there is room for a great deal of improvement in this measure. In NC, almost 40% of women in 2008 gained greater than the recommended ideal amount of weight.

Activities for FY09 included promotion of the revised maternal health clinic flow sheet to increase attention to women gaining outside of the IOM gestational weight guidelines and awareness and education activities in anticipation of revised IOM gestational weight guidance.

The WIC Program implemented a "Move to Lower Fat Milk" educational campaign and a policy that women who participate in WIC no longer receive whole milk (unless medically prescribed), but instead have a "point-of-purchase" choice of skim, 1%, or 2% milk.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Staff training.				X
2. Client education and awareness.		X		
3. Anthropometric data collection and assessment.	X			
4. Data analysis.				X
5. Monitoring/surveillance of prenatal weight gain				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The LHD Maternal Health and High Risk Maternity Clinic Agreement Addenda were revised to reflect the new IOM gestational weight gain guidance released in May 2009. These new guidelines were highlighted and distributed, along with BMI calculation wheels, to all LHDs serving prenatal clients. Education about the new guidance was also provided through presentations for maternal health care practitioners in some counties.

Technical assistance was provided to maternity clinic health care professionals regarding the use of the new clinic flow sheet which includes a formula for flagging women who gain outside the IOM guidelines.

The NSB is implementing federally mandated changes to the WIC Food Package so that it more closely aligns with the Dietary Guidelines For Americans and offers greater flexibility to meet cultural and nutritional needs (including appropriate prenatal weight gain) of program participants. Educational activities are being implemented to support the changes in the food package. The NSB is developing and implementing a new prenatal weight gain chart based on the 2009 IOM guidelines. This tool will be used by public health staff to assess, monitor, and educate clients' prenatal weight gain. Annually with the WIC Program Agreement Addenda, the NSB continues to provide 10-year trend data (updated according to new 2009 IOM guidelines) on women who receive WIC Program services during pregnancy and who gain inadequate/recommended/excessive weight.

c. Plan for the Coming Year
Activities for FY11 will include continued education about the revised gestational weight gain guidance and the importance of a healthy weight during pregnancy as well as continued promotion of the revised maternal health clinic flow sheet to increase attention to women gaining outside of the IOM gestational weight guidelines. Healthy weight in pregnancy promotion and guidance will also extend beyond local health department maternity clinics and include community based organizations working with prenatal women which also have a lifestyle behavior component (e.g. Healthy Beginnings projects).

The NSB will continue to provide 10-year trend data on the number and percent of women who receive WIC Program services during pregnancy and who gain inadequate/recommended/excessive weight according to the 2009 IOM guidelines. The WIC Program will continue to provide nutrition education to prenatal participants on prenatal weight gain.

State Performance Measure 9: *Percent of non-pregnant women of reproductive age who are overweight/obese (BMI>26).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective		45	44	43	42
Annual Indicator	46.3	46.6	46.7	47.2	47.8
Numerator	19693	20048	21109	21314	23311
Denominator	42533	43022	45201	45157	48768
Data Source				NC Pregnancy Nutrition Surveillance System	NC Pregnancy Nutrition Surveillance System
Is the Data Provisional or Final?				Final	Final
	2010	**2011**	**2012**	**2013**	**2014**
Annual Performance Objective	41	40	40	40	

Notes - 2009
Data are based on the prior calendar year. The data source is the North Carolina Pregnancy Nutrition Surveillance System (PNSS) which links data from the WIC program, public maternity clinics, birth certificates and fetal death certificates.

Notes - 2008
Data are based on the prior calendar year. The data source is the North Carolina Pregnancy Nutrition Surveillance System (PNSS) which links data from the WIC program, public maternity clinics, birth certificates and fetal death certificates.

Notes - 2007
Data are based on the prior calendar year. The data source is the North Carolina Pregnancy Nutrition Surveillance System (PNSS) which links data from the WIC program, public maternity clinics, birth certificates and fetal death certificates.

a. Last Year's Accomplishments

For 2008, the PNSS revealed that 47.8% of WIC clients had a prepregnancy BMI that fell into the overweight or obese categories, which compares to 44.5% nationally in 2007. The highest rates occurred in 2008 among black women and women 30 years of age and above (53.8% and 63.6%, respectively).

The healthy weight training module was provided to health practitioners, faith based advisors, and community outreach workers for the First Time Motherhood grant. The healthy weight training was also provided for the March of Dimes Preconception Transition Team (subcommittee of the NC Folic Acid Council) as they incorporate healthy weight into their messaging for healthy behaviors for women of childbearing age. Networking continued with the NC Fruit & Veggies Nutrition Coalition to promote increased access to and increased consumption of fruit and vegetables in women of childbearing age in NC. Finally, an article for health care professionals about the problem of overweight in women with suggestions for preventing and treating overweight was published in the September/October 2009 issue of the NC Medical Journal.

The WIC Program implemented a "Move to Lower Fat Milk" educational campaign and a policy that women who participate in WIC no longer receive whole milk unless medically prescribed.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Client assessment.	X			
2. Client education.		X		
3. Staff training.				X
4. Data collection and assessment.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Current activities include the development of written educational materials to fill the identified gap for more comprehensive materials to address overweight in women for both English and Spanish speaking women. Also, healthy weight awareness and education is being incorporated into programs outside of the local health departments such as Healthy Beginnings.

The WIC Program is implementing federally mandated changes to the WIC Food Package which were designed to help address current health issues including overweight. In addition to the change requiring that women receive only low fat milk (unless medically prescribed), the food package will include fruits and vegetables (fresh, frozen, and canned) and whole grain options (breads, cereals, tortillas, and rice). Educational activities will be implemented to support changes in the food packages. For women participating in the WIC Program, the NSB continues to emphasize assessment of and education about postpartum BMI, healthy weight, and nutrition and physical activity behaviors related to achieving a healthy weight. The NSB revised the WIC Nutrition Assessment and Care Plan form to include the assessment of nutrition and physical activity behaviors related to achieving a healthy weight and offered training on these forms and assessment activities.

c. Plan for the Coming Year

Focusing on continued awareness and education activities about healthy weight in women before, during and after pregnancy is an on-going priority for FY11. Assessing communities to identify and promote available resources that affect lifestyle behaviors for women and the distribution of more comprehensive materials to meet clinicians' needs to address overweight in women are planned.

The NSB will continue educational activities to support the WIC food packages. For women participating in the WIC Program., the NSB will continue to emphasize assessment of and education about postpartum BMI, healthy weight, and nutrition and physical activity behaviors related to achieving a healthy weight.

E. Health Status Indicators

Introduction

The WCHS uses the Health Status Indicators (HSI) in a variety of ways. They provide information on the residents of NC which assists in public health efforts, but they are used by the WCHS primarily as a surveillance or monitoring tool as they are updated each year for the MCH Block Grant application and as evaluative measures. Taken as a whole, they are certainly an important part of the data reviewed during the five-year Needs Assessment process.

Other indicators are used in community monitoring sessions at local health departments. Child health and women's health nurse consultants and social work consultants work together in teams to provide program consultation to county health department and community agency staff. County and state level data are available for use in these monitoring sessions.

In addition, some of the indicators were used in the Shared Indicators for School Readiness project which is part of the ECCS grant.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.1	9.2	9.1	9.2	9.1
Numerator	10846	11353	11595	12100	11929
Denominator	119773	123040	127646	130886	130758
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008

Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007

Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
Low weight births, those weighing less than 2500 grams, made up 9.1% of all births in the state in 2008. This rate has been steadily increasing since 1988. Minority rates were nearly double those of white women in 2008 (13.5% vs. 7.3%). National data shows that 8.2 percent of births in the US were born weighing less than 2500 grams in 2007. Southeastern region data are available by race for 2007, and North Carolina's percentages of 7.5% for white births and 14.6% for black births are consistent with the regional rates of 7.6% for whites and 14.6% for blacks.

Many women of childbearing age in NC are entering pregnancy with risk factors that affect their health as well as that of their babies. Over half of the North Carolina women in this age group are overweight or obese, almost 47% don't get the physical activity they need and another 21% use tobacco. In addition 28% report poor mental health and 12% report alcohol misuse. High blood pressure affects 10 percent of these women and at least 3 percent have diabetes. Complicating their access to care, over 22% of women in this age group do not have health insurance (NC BRFSS 2007 and 2008). Many of these risk factors not only affect the women themselves, but can negatively impact their pregnancies as well. These risk factors and conditions can increase the risk of delivering a preterm and/or low birth weight baby. Premature infants are more likely to have health problems throughout their lives. In addition, women with some of these risk factors are more likely to deliver a baby born with birth defects or other serious long-term medical conditions.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	7.3	7.4	7.3	7.4	7.3
Numerator	8437	8754	9056	9409	9201
Denominator	115855	118775	123475	126471	126358
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
While the increase in multiple births may contribute to the high percentage of low birth weight infants, the percent of low birth weight singleton births has not decreased in NC over the past five years either. The percentage has remained at about 7.3 percent for the past five years (2004 to

2008). For more information on low birth weight babies born in NC, refer to the narrative on HSI 1A.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.9	1.9	1.8	1.8	1.8
Numerator	2291	2300	2346	2416	2296
Denominator	119773	123040	127646	130886	130758
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
The percent of very low birth weight births (<=1500g) has remained stable at about 1.8 from 2004 to 2008, which is higher than the 2006 national percentage of 1.14. The racial disparity seen in low birth weight births exists also in the very low birth weight category. The percent of white births with a very low birth weight was 1.2, while for all other races combined the percentage was 3. For more information on low birth weight babies born in NC, refer to the narrative on HSI 1A.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	1.5	1.4	1.4	1.4	1.4
Numerator	1723	1719	1751	1811	1732
Denominator	115855	118775	123475	126471	126358
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
While the increase in multiple births may contribute to the high percentage of very low birth weight infants, the percent of very low birth weight singleton births has not decreased in NC over the past five years either. The percentage has remained at about 1.4 percent for the past five years (2004 to 2008). For more information on low birth weight babies born in NC, refer to the narrative on HSI 1A.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	10.6	9.3	9.5	9.6	8.3
Numerator	183	163	170	175	152
Denominator	1731988	1751959	1788230	1823562	1829372
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
The death rate per 100,000 due to unintentional injuries among children less than or equal to 14 years dropped to 8.3 in 2008, a fourteen percent decrease from 2007. The value for this indicator had remained between 9 and 10 for the years 2003 to 2007, with the exception of a rate of 10.6 in 2004. National and state data for 2007 from the Web-based Injury Statistics Query and Reporting System (WISQARS) show that the North Carolina rate at 9.65 per 100,000 was higher than the national rate of 8.33.

The C&Y Branch has played a key role in the development and implementation of the NC Child Fatality Prevention System that serves as a central resource for action related to reducing preventable child deaths. The enabling legislation passed in 1991 created the four components

of this system: the NC Child Fatality Task Force (CFTF); the State Child Fatality Prevention Team; local Child Fatality Prevention Teams (CFPTs); and Community Child Protection Teams (CCPTs) in each county. Locally, the CCPTs focus on fatalities that are likely due to child abuse, neglect, or dependency, while the CFPTs focus on all other child fatalities. These teams review deaths and initiate system changes at the local level that will help prevent child deaths. The local teams can also make recommendations to the State Team and the Task Force for state level changes.

The Task Force is a critical resource for routine analysis of child fatalities in the state. It is unique in its ability to assure introduction of legislation related to reducing child fatalities. Task Force membership includes legislators, leaders of state agencies (health, social services, juvenile justice, and education), child advocacy organizations, and child abuse prevention organizations. The State Team is responsible for in-depth reviews of all deaths of children younger than eighteen years old reported to the NC Medical Examiner system, including deaths due to abuse and neglect.

The Executive Director of the Task Force and the state coordinator for the CFPTs are housed in C&Y Branch providing a mechanism for leadership and participation in Task Force activities. These staff members work closely with the staff of the Injury and Violence Prevention Branch located in the Chronic Disease and Injury Section of DPH. Additional partners include other state agencies and non-profit agencies such as North Carolina Safe Kids, the University of North Carolina Injury Prevention Center, and the Governor's Highway Safety Program.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	5.5	4.7	5.0	4.0	3.0
Numerator	96	82	90	73	54
Denominator	1731988	1751959	1788230	1823562	1829372
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:

The death rate per 100,000 due to unintentional injuries due to motor vehicle crashes among children less than or equal to 14 years had fluctuated between 4 and 5.5 for the years 2003 to 2007. However, in 2008, the rate dropped to 3 per 100,000, a twenty-five percent decrease from 2007. National and state data for 2007 from WISQARS show that the North Carolina rate at 4.03 per 100,000 was higher than the national rate of 3.22.

The CFTF has been instrumental in supporting legislation to prevent these deaths. For example, in 2004, the NC Booster Seat Law was ratified, establishing that a child less than eight years of age and less than 80 pounds in weight shall be properly secured in a weight-appropriate child passenger restraint system. Also, in 2008, the Transporting Children in Open Bed of Vehicle Bill was ratified. This bill increases the protection of children who ride in the back of pickup trucks or open beds of vehicles by raising the minimum age to 16 and removing the exemption that made allowances for small counties.

For more information, see the narrative for National Performance Measure 10.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	34.8	31.0	29.5	30.5	25.3
Numerator	430	390	377	401	344
Denominator	1233909	1256605	1278943	1315580	1358075
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					Final

Notes - 2009
Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
The death rate per 100,000 due to unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years decreased during the years 2003 to 2007 and fell even more to 25.3 per 100,000 in 2008. National and state data for 2007 from WISQARS show that the North Carolina rate at 32.98 per 100,000 was higher than the national rate of 24.92. In North Carolina, the rate for males in 2007 was 47.09 as compared to a rate of 17.74 for females. This difference was also found in national data, with a rate of 35.17 for males and 14.08 for females.

Legislation proposed and supported by the CFTF to prevent these motor vehicle deaths include the introduction of a graduated driver's license in 1997 and various improvements to this

legislation over the past few years. Among other features, the measure limits the hours that new drivers may drive during those especially vulnerable months between age sixteen and sixteen-and-a-half as well as limits the number of minor-age passengers. In addition, in 2006, a law prohibiting cell phone use while driving (with a few exceptions) for youth under age 18 was enacted.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	323.7	339.2	333.8	339.4	347.6
Numerator	5606	5943	5969	6190	6358
Denominator	1731988	1751959	1788230	1823562	1829372
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
The data source for the number of all nonfatal injuries among children less than or equal to 14 years is state E-coded hospital discharge data. Rates in NC have increased from 307.6 per 100,000 in 2003 to 347.6 in 2008.

Work done through the Child Fatality Prevention System in North Carolina is critical to stopping and reversing this trend. The WCHS will continue to work with the Injury and Violence Prevention Branch to promote prevention efforts and to improve data capacity in this area.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	26.6	23.4	22.5	24.1	17.1
Numerator	461	410	403	439	313
Denominator	1731988	1751959	1788230	1823562	1829372
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator: In the 2007 application, these data were changed from reports of all motor vehicle injuries per the UNC Highway Safety Research Center to just those injuries reported in hospital discharge data.
Denominator: Population Estimates from the NC SCHS.

Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Numerator: In the 2007 application, these data were changed from reports of all motor vehicle injuries per the UNC Highway Safety Research Center to just those injuries reported in hospital discharge data.
Denominator: Population Estimates from the NC SCHS.

Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Numerator: In the 2007 application, these data were changed from reports of all motor vehicle injuries per the UNC Highway Safety Research Center to just those injuries reported in hospital discharge data.
Denominator: Population Estimates from the NC SCHS.

Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
The data source for the number of all nonfatal injuries due to motor vehicle crashes among children less than or equal to 14 years is state E-coded hospital discharge data. Rates in NC fluctuated between 22.5 to 26.6 per 100,000 during 2003 to 2007, but dropped to 17.1 in 2008..

Again, the work done through the Child Fatality Prevention System in North Carolina is important in maintaining the improvement in this indicator. The WCHS will continue to work with the Injury and Violence Prevention Branch to promote prevention efforts and to improve data capacity in this area.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	136.4	133.8	128.7	131.7	110.8
Numerator	1645	1681	1646	1733	1505
Denominator	1206204	1256605	1278943	1315580	1358075
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009
Numerator: In the 2007 application, these data were changed from reports of all motor vehicle injuries per the UNC Highway Safety Research Center to just those injuries reported in hospital discharge data.
Denominator: Population Estimates from the NC SCHS.

Data are for the prior CY, e.g., FY09 is really CY08 data.

Notes - 2008
Numerator: In the 2007 application, these data were changed from reports of all motor vehicle injuries per the UNC Highway Safety Research Center to just those injuries reported in hospital discharge data.
Denominator: Population Estimates from the NC SCHS.

Data are for the prior CY, e.g., FY08 is really CY07 data.

Notes - 2007
Numerator: In the 2007 application, these data were changed from reports of all motor vehicle injuries per the UNC Highway Safety Research Center to just those injuries reported in hospital discharge data.
Denominator: Population Estimates from the NC SCHS.

Data are for the prior CY, e.g., FY07 is really CY06 data.

Narrative:
The data source for the number of all nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years is state E-coded hospital discharge data. Rates in NC have decreased from 142.5 per 100,000 to in 2003 to 110.8 in 2008.

Again, the work done through the Child Fatality Prevention System in North Carolina will be necessary for this trend to continue. The WCHS will continue to work with the Injury and Violence Prevention Branch to promote prevention efforts and to improve data capacity in this area.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	36.0	36.5	32.0	39.6	44.8
Numerator	10366	10811	9689	12123	13716
Denominator	287759	295912	302427	306177	306177
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Rate denominators were calculated using the latest available bridged race population estimates from the National Center for Health Statistics. Because bridged race population estimates were unavailable for 2009, 2008 estimates were used as denominators in rate calculation for 2009. Thus, the 2009 rates should be considered preliminary.

Narrative:
The rate per 1000 women aged 15 through 19 years with a reported case of Chlamydia has fluctuated and risen over the past five years, increasing from 36 per 1000 in 2005 up to 44.8 in 2009, although there was a drop in the rate to 32 in 2007.

North Carolina law states that all cases of Chlamydia infection must be reported to the local health department within seven days. Laboratory confirmation of Chlamydia takes place at a number of private labs; most public clinics send their samples to the State Laboratory of Public Health. The provider reports laboratory confirmed Chlamydia to the local health department. Infected patients are treated and encouraged to bring their partners in for testing.

Beginning in 2008, morbidity reports are forwarded electronically to the Communicable Disease Surveillance Unit via the North Carolina Electronic Disease Surveillance System (NC EDSS). This reporting of morbidity through NC EDSS represents a substantial improvement in surveillance reporting for laboratory-based diseases. However, because implementation of NC EDSS requires extensive changes in surveillance procedures, morbidity data for 2008 and 2009 should be viewed with this in mind. The data for females is more complete, although cases are still underreported and may be biased toward public clinics which are more likely to screen and report cases.

Chlamydia is predominantly found in younger age groups. For females the rates for 15 to 19 years olds and 20 to 24 year olds are close, with 15 to 19 year olds having the highest rates in 2004 through 2006 20 to 24 year olds having slightly higher rates in 2007 through 2009. Over the past five years, reported cases and rates have generally been on the rise for all age groups, most likely reflecting more screening. The increase observed in 2009 likely reflects reporting issues rather than changes in morbidity or screening.

Racial disparities in all female Chlamydia reports have remained fairly stable over the past five years (2005-2009), with a rate about seven times higher among black females than among whites; and a rate three to four times higher among American Indian/Alaska Native and Hispanic females than among white females.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2005**	**2006**	**2007**	**2008**	**2009**
Annual Indicator	9.5	10.2	9.4	11.1	13.0
Numerator	14675	15839	14911	17555	20694
Denominator	1541266	1557051	1579823	1586316	1586316
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over					

the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009
Rate denominators were calculated using the latest available bridged race population estimates from the National Center for Health Statistics. Because bridged race population estimates were unavailable for 2009, 2008 estimates were used as denominators in rate calculation for 2009. Thus, the 2009 rates should be considered preliminary.

Notes - 2008
Rate denominators were calculated using the latest available bridged race population estimates from the National Center for Health Statistics. Because bridged race population estimates were unavailable for 2008, 2007 estimates were used as denominators in rate calculation for 2008. Thus, the 2008 rates should be considered preliminary.

Notes - 2007
Rate denominators were calculated using the latest available bridged race population estimates from the National Center for Health Statistics. Because bridged race population estimates were unavailable for 2007, 2006 estimates were used as denominators in rate calculation for 2007. Thus, the 2007 rates should be considered preliminary.

Narrative:
The rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia has increased from 9.52 per 1,000 in 2005 to 13.05 in 2009. As noted in HSI5A, Chlamydial infection is often asymptomatic in both males and females, and most cases are detected through screening. Changes in the number of reported cases may be due to changes in screening practices, but with the reporting practices changing with the introduction of NC EDSS in 2008, trend data are hard to interpret.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	134248	90968	34037	2128	2932	180	4003	0
Children 1 through 4	518575	364080	116885	7589	12255	605	17161	0
Children 5 through 9	623448	438496	143610	8934	13735	658	18015	0
Children 10 through 14	594738	409922	150504	8338	12311	471	13192	0
Children 15 through 19	628992	425227	173014	9242	11094	464	9951	0
Children 20 through 24	627073	439760	158900	9138	10448	579	8248	0
Children 0 through 24	3127074	2168453	776950	45369	62775	2957	70570	0

Notes - 2011
Data source for all data in HSI 06 is the US Census Bureau - Population Estimates for 2008.

Narrative:
Population estimates for HSI6A come from the US Census Bureau. In 2008, there were just over 3.1 million children and youth (infants to age 24) estimated to be living in NC. This is an increase of about 180,000 children (or 6% increase) from the estimates for 2004. The 10 to 14 age group decreased by about 7600 children from 2004 to 2008, but all the other age groups increased. The number of children in all race groups increased during this time period.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	110904	23344	0
Children 1 through 4	432272	86303	0
Children 5 through 9	543571	79877	0
Children 10 through 14	540742	53996	0
Children 15 through 19	584462	44530	0
Children 20 through 24	576337	50736	0
Children 0 through 24	2788288	338786	0

Notes - 2011

Narrative:
Population estimates for HSI6B come from the US Census Bureau. In 2008, there were just over 3.1 million children and youth (infants to age 24) estimated to be living in NC. Almost 11% (338,786) of these children and youth were of Hispanic ethnicity. This is an increase from 2004, when 8.6% were of Hispanic ethnicity. There were increases of children of Hispanic origin in each of the age groups listed from 2004 to 2008 with the exception of the 20 to 24 year age group, which declined by 8,283.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	235	105	123	5	1	0	0	1
Women 15 through 17	4730	2720	1832	117	35	0	0	26
Women 18 through 19	10398	6139	3841	243	114	1	0	60
Women 20	98811	71458	22722	1280	3077	27	0	247

through 34								
Women 35 or older	16578	12802	2805	137	791	2	0	41
Women of all ages	130752	93224	31323	1782	4018	30	0	375

Notes - 2011
The data for the category "more than one race reported" are not available for any of the age groups in this indicator.

The data source for these data is the birth file from the State Center for Health Statistics. There were 6 births in 2008 to women of unknown age which are not included in these totals. Four of these births were to white women and 2 were to black women. Three have unknown Hispanic ethnicity and three were not Hispanic.

Narrative:
The total number of births reported in NC for 2008 according to state vital records was 130,758. This is a nine percent increase in births since 2005, when the total number of births was 119,773. Over 75% of the births were to women between the ages of 20 to 34. The number of births to women <15 decreased by 51 from 286 in 2004 to 235 in 2008, but there were increases in all of the other age groups. In 2008, 71% of all births in NC were to white women (both Hispanic and non-Hispanic included), 24% to black women, 3% to Asian women, and 1.4% to American Indian or Alaskan Native women.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	177	57	1
Women 15 through 17	3672	1043	15
Women 18 through 19	8747	1638	13
Women 20 through 34	81883	16824	104
Women 35 or older	14496	2057	25
Women of all ages	108975	21619	158

Notes - 2011

Narrative:
The total number of births to women of Hispanic origin reported in NC for 2008 according to state vital records was 21,619. This is an increase of 25% in births since 2004, when the total number of births to women of Hispanic origin was 17,291. About 78% of all Hispanic births were to women age 20 to 34. Almost 70% of these births were to women of Mexican heritage.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	1066	558	460	27	21	0	0	0
Children 1 through 4	146	82	55	2	7	0	0	0
Children 5 through 9	89	57	29	0	3	0	0	0
Children 10 through 14	90	55	35	0	0	0	0	0
Children 15 through 19	427	276	128	17	6	0	0	0
Children 20 through 24	662	442	196	20	4	0	0	0
Children 0 through 24	2480	1470	903	66	41	0	0	0

Notes - 2011
Data for the category "More than one race reported" are not available for indicator for any age group.

Narrative:
The infant mortality rate in NC in 2008 was 8.2 deaths per 1,000 live births, which is a 3.5 percent decrease from the 2007 rate of 8.5. The 2008 minority rate was the lowest in the state's history at 13.5, but racial disparities in infant mortality continued; the minority rate is still more than double the white rate. Over the three-year period 2006-2008, black non-Hispanics have experienced the highest average infant mortality rate, 14.9 deaths per 1,000 live births, followed by American Indian non-Hispanics (14.0), and white non-Hispanics (6.1).

Data for 2008 show a total decrease of 18 deaths to children and youth ages infant to 24 as compared to the number of deaths in 2004, with the decreases coming in the 5 to 19 year old age groups.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	936	130	0
Children 1 through 4	129	16	1
Children 5 through 9	83	5	1
Children 10 through 14	83	7	0
Children 15 through 19	393	33	1
Children 20 through 24	588	74	0
Children 0 through	2212	265	3

24			

Notes - 2011

Narrative:
The number of Hispanic infant deaths increased by 49 from 81 in 2004 to 130 in 2008, and the Hispanic infant mortality rate increased from 4.68 in 2004 to 6.0 in 2008. The child death rate for Hispanic children and youth ages 1 to 24 decreased from 80.2 per 100,000 in 2004 to 78.2 per 100,000 in 2008. The death rates decreased in the lower age groups (1 to 4 and 5 to 9), but increased in the three higher age groups.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	2500001	1728693	618050	36231	52327	2378	62322	0	2008
Percent in household headed by single parent	21.3	13.8	41.1	28.2	6.7	13.5	22.7	0.0	2008
Percent in TANF (Grant) families	4.3	1.8	9.6	5.6	1.5	5.3	0.4	0.0	2009
Number enrolled in Medicaid	1001081	405196	377183	16869	12537	1313	0	187983	2009
Number enrolled in SCHIP	130762	62666	41739	2026	2205	166	0	21960	2009
Number living in foster home care	9878	5047	4042	132	13	45	512	87	2009
Number enrolled in food stamp program	769847	290950	337968	13169	7648	976	1737	117399	2009
Number enrolled in WIC	208236	122541	66502	3163	2818	217	0	12995	2009
Rate (per 100,000) of juvenile crime arrests	2283.0	1403.0	5164.0	2809.0	511.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	4.3	3.6	5.3	5.5	1.8	0.0	4.5	0.0	2009

Notes - 2011

US Census Bureau 2008 Population Estimates

Based on 2000 US Census data. Data are not available for the Other and Unknown categories.

State fiscal year 2009 data from DSS. Unreported and missing ethnicity are counted as non-Hispanic.

Data are as of December 31, 2008 for ages 0-19. Data are not available for the > one race reported category.

Data are per a snapshot as of June 2009 per a Data Warehouse Query by DMA employee (Cinnamon Narron - 6/10 email).

State fiscal year 2009 data from DSS. Unreported and missing ethnicity are counted as non-Hispanic.

Data are for State Fiscal Year 2009. Data are not available for the > one race reported category.

Data are for CY08. Data are not available for the Native Hawaiian or Other Pacific Islander, > one race reported, and Other and Unknown Categories. Data Source: NC State Bureau of Investigation North Carolina Uniform Crime Reporting (UCR) Program.

Data Source: NC Department of Public Instruction's Report on Dropout Events and Rates.

Narrative:
These data are collected from a variety of different sources which are cited in the field level notes. The major sources are US Census Data, NC DSS data systems, NC DPI data systems, and WCHS data systems. Most indicators are updated annually, but some, particularly those based on US Census data will not change annually.

There does not seem to be a lot of movement, either positive or negative, in most of these indicators over the previous five years. The percent of children in families in TANF has decreased from 6.85 in SFY03 to 4.3 in SFY09. This decrease appears to be true across racial and ethnic categories.

The number of children enrolled in Medicaid has increased from 632,585 as of December 2004 to 762,312 as of December 2008, a 21% increase. The largest percent increases are found in the Native Hawaiian or Other Pacific Islander and Asian categories, with increases of almost 50% or more. Whites on Medicaid increased 24% during this time period, with blacks only increasing 7%.

The number of children living in foster care decreased from 14,841 in SFY03 to 9,878 in SFY09, but the number of children enrolled in the food stamp program increased from 503,818 to 769,847 during this same period. The number of children enrolled in WIC also increased from 161,427 in SFY04 to 208,236 in SFY09. The number of juvenile crime arrests decreased slightly from CY2003 (53,126 arrests) to CY2008 (51,222 arrests).

The annual dropout rate is calculated by DPI each year. Their calculation defines a dropout as a student who was enrolled in school at some time during the previous school year, which is the reporting year; was not enrolled on Day 20 of the current school year; has not graduated from high school or completed a state or district approved education program; and does not meet certain reporting exclusions. This rate has remained fairly stable over time, with the rate for school year 2003-04 (SY04) reported to be 4.86 and the rate in SY09 reported to be 4.27. The rate for SY07 spiked at 5.24. In addition to the annual dropout rate, DPI calculates a Cohort Graduation Rate which illustrates what percentage of ninth graders has graduated from high

school four years later. These data show that NC's rate increased from 68.3% in SY06 to 71.8% in SY09. Data for SY08 also indicated that females graduate at a higher rate than males (76.6% versus 67.1%) and Asians graduate at a higher rate than other racial groups (83.7% compared to 77.7% for white, 63.2% for black, 71.5% for multi-racial, and 60% for Native American students).

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	2211951	288050	0	2008
Percent in household headed by single parent	23.0	8.9	0.0	2008
Percent in TANF (Grant) families	4.4	3.3	0.0	2009
Number enrolled in Medicaid	671480	142669	186932	2009
Number enrolled in SCHIP	101292	16468	13002	2009
Number living in foster home care	9097	781	0	2009
Number enrolled in food stamp program	684540	85307	0	2009
Number enrolled in WIC	144165	64071	0	2009
Rate (per 100,000) of juvenile crime arrests	2283.0	2283.0	0.0	2009
Percentage of high school drop-outs (grade 9 through 12)	4.3	5.7	0.0	2009

Notes - 2011
Data Source: US Census Bureau 2008 Population Estimates. Ethnicity Not Reported Category data are not available.

Data are as of December 31, 2008, for ages 0-19. Data are not available for the > one race reported category.

Data are per a snapshot as of June 2009 per a Data Warehouse Query by DMA employee (Cinnamon Narron - 6/10 email).

State fiscal year 2009 data from DSS. Unreported and missing ethnicity are counted as non-Hispanic. Ethnicity Not Reported Category data are not available.

Data are for State Fiscal Year 2009. Ethnicity Not Reported Category data are not available.

These data are not available. This is an estimate, taking the rate for children of all races in 9A and applying that to the total population in 9B.

Data Source: NC Department of Public Instruction's Report on Dropout Events and Rates. Hispanic Ethnicity was not separated out from Race, however, so just put overall rate of 4.3% for non-Hispanic.

Narrative:

These data are collected from a variety of different sources which are cited in the field level notes. The major sources are US Census Data, NC DSS data systems, NC DPI data systems, and WCHS data systems. Most indicators are updated annually, but some, particularly those based on US Census data will not change annually.

The percent of Hispanic children in families receiving TANF increased from 2.3% in SFY03 to 3.3% in SFY09. The number of Hispanic children on Medicaid increased from 27,678 as of December 2004 to 109,153 as of December 2008, which is almost a 300 percent increase. The number of Hispanic children in foster care decreased between SFY06 (846 children) and SFY09 (781 children). However, the number of children enrolled in the Food Services and Nutrition Services program almost tripled from SFY03 (30,393 children) to SFY09 (85,307 children). The number of Hispanic children less than 6 years of age receiving WIC also increased by about 15,000 children from SFY06 to SFY09.

While Hispanic ethnicity is not separated out from race in the annual dropout report (it's reported as a race category) the trend data for Hispanic dropouts of is encouraging as it has fallen from 7.38 in SY04 to 5.71 in SY09. The 4-year Cohort Graduation Rate for Hispanics also shows improvement from 51.8% in SY06 to 59% in SY09; however there is much more room for improvement in this indicator.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	1332079
Living in urban areas	1173574
Living in rural areas	787158
Living in frontier areas	0
Total - all children 0 through 19	1960732

Notes - 2011
Data Source: Table GCT-P% Age and Sex: 2000; Geographic Area: North Carolina - Urban/Rural and Inside/Outside Metropolitan Area; US Census Bureau, Census 2000 Summary File 1, Matrices PCT12 and P13

Data Source: Table GCT-P% Age and Sex: 2000; Geographic Area: North Carolina - Urban/Rural and Inside/Outside Metropolitan Area; US Census Bureau, Census 2000 Summary File 1, Matrices PCT12 and P13

Data Source: Table GCT-P% Age and Sex: 2000; Geographic Area: North Carolina - Urban/Rural and Inside/Outside Metropolitan Area; US Census Bureau, Census 2000 Summary File 1, Matrices PCT12 and P13

Narrative:
Data for this measure come from the Census 2000 Summary File 1 based on the percent of total population under 18 years of age. About 60% of all children under 18 in North Carolina live in urban areas, with the remaining 40% living in rural areas as defined by the US Census Bureau. About 67% of children in NC live in a metropolitan statistical area, which can be made up of both rural and urban areas.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	9234000.0
Percent Below: 50% of poverty	5.7
100% of poverty	13.9
200% of poverty	35.2

Notes - 2011
POV46 Poverty Status by State; US Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement

This is a complete estimate based on data for the US as a whole. Source: U.S. Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement. Table POV01: Age and Sex of All People, Family Members and Unrelated Individuals Iterated by Income-to-Poverty Ratio and Race: 2008 Below 50% of Poverty -- All Races

POV46 Poverty Status by State; US Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement

POV46 Poverty Status by State; US Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement

Narrative:
The data source for this measure is Table POV46 - Poverty Status by State, published by the US Census Bureau, based on data from the Current Population Survey, using both the 2005 and 2009 Annual Social and Economic Supplements. The 2005 data showed that 14.6% of the population lived below 100% of the federal poverty level while 34.4% lived below 200% of the federal poverty level. These percentages changed to 13.9 and 35.2 respectively in the 2009 supplement. State data are not available from these supplements for the percentage of people below 50% of the federal poverty level, thus 5.7%, which is the US total from the 2009 supplement, has been entered for this indicator.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2500001.0
Percent Below: 50% of poverty	8.0
100% of poverty	19.8
200% of poverty	43.0

Notes - 2011
Population Estimate from US Census for 2008

This is 2008 American Community Survey data per the Annie E. Casey Foundation website (NC profile)

his is 2008 American Community Survey data from S0901. Children Characteristics

This is 2008 American Community Survey data per the Annie E. Casey Foundation website (NC profile)

Narrative:
The percent of children in NC at various levels of the federal poverty level are found on the Annie E. Casey Foundation website in the NC Profile. These data are taken from the American Community Survey. Data from the 2005 survey show that 9% of children 19 years and under lived below 50% of the federal poverty level, 21% lived below 100% of the federal poverty level, and 44% lived below 200% of the federal poverty level. These percentages remained about the same the 2008 survey, with 8% at 50% of the federal poverty level, 19.8% at 100% of the federal poverty level, and 43% at 200% of the federal poverty level.

F. Other Program Activities

MCH Hotline - NC's Family Health Resource Line (1-800-FOR-BABY or 1-800-327-2229) has evolved from a prenatal care hotline to a multi-program resource. The hotline averages 3,500-4,000 calls a month and operates 24 hours a day, including holidays.

In 1990, North Carolina launched First Step, an infant mortality public awareness campaign, which included a statewide toll-free number. The line responded to calls related to preconceptional, prenatal, postpartum, and infant care; breastfeeding and nutrition; and Baby Love (Medicaid for pregnant women). In 1994, the Health Check Hotline (Medicaid for children) was launched. The line was co-located with the First Step Hotline, using the same staff but a separate toll-free number. With this expansion, the hotline's mission broadened to encompass child health topics. That same year, the First Step Hotline added a focus on prenatal substance use prevention and treatment. In 1998, programs pooled resources to create the NC Family Health Resource Line. The state's Smart Start Program, a public-private initiative that provides early education funding to all of the state's counties, became a partner and contributed early child development and parenting resources, and the Health Choice Program (SCHIP) marketed the line as their "call to action" to learn more about free and low-cost health insurance. In 2002, the NC Child Care Health and Safety Resource Center was merged into the NC Family Health Resource Line, again expanding breadth of services and resources. The NC Family Health Resource Line is funded by state dollars, federal Medicaid matching dollars and MCH grant funds.

In December 2009, the NC Family Health Resource Line became an automated system to triage calls and forward them to existing call centers based on the choices made by the caller. This change in service was prompted by a state budget crisis that required consolidation of existing hotline services. Calls relating to maternal and child health issues, family health, Health Check (Medicaid for Children), and NC Health Choice are routed directly to the CARE-LINE, NCDHHS's toll-free information and referral telephone service. Information and Referral Specialists provide information and referrals regarding human services in government and non-profit agencies. Currently, sixteen individuals staff the CARE-LINE. Of these staff, one specialist is the Office of Citizen Service's CARE-LINE Hispanic Citizen Services Representative and is dedicated to handling calls from Spanish-speaking customers. CARE-LINE staff members are well trained and have a wealth of knowledge regarding human service programs across North Carolina. Many staff persons are Certified Information and Referral Specialist by the National Alliance of Information and Referral Services. In FY 2009, these professionals provided information to more than 300,000 callers.

A second option in the NC Family Health Resource Line menu will direct families of CSHCN to

the Title V CSHCN hotline which is operated (but not funded) by Title V.

Collaboration is a key strength of the NC Family Health Resource Line. The hotline is one of the few that has an advisory committee exclusively dedicated to oversight. Members of the committee include representatives from UNC-Chapel Hill, Title V, Medicaid, CSHCN, CARE-LINE, and other key stakeholders. With the hiring of a full-time parent liaison in the C&Y Branch and her work with the Family Council, the resource line has greater parental involvement.

In addition, the NCDHHS Office of Citizen Services that supports the CARE-LINE has also developed a website (NCcareLINK.gov) that provides up-to-date information about programs and services across North Carolina for families, seniors, youths and everyone in-between. It is a collaborative effort of NC DHHS and many other government and non-profit information and referral stakeholders across North Carolina.

Data Collection - Two major emerging issues on the horizon are in the area of data collection and comparability. In 2010, the NC State Center for Health Statistics plans to roll out the National 2003 birth certificate. This roll out will be in phases, and as a result, data compatibility for the calendar year of 2010 will be difficult. In addition to not being able to compare ourselves with all of the US because some states are using the old certificate, we will also not be able to compare ourselves backwards in all measures. Also, any data collected in 2010 will not be able to be compared within the year because part of the year will be the old certificate and some the new.

In addition the birth certificate, as mentioned in the data sources, North Carolina is in the process of implementing a new Health Information System (HIS) to replace the old Health Services Information System (HSIS). Statewide rollout is scheduled to take place from April to August 2010. This system will be used by all local health departments, directly or indirectly through batch reporting from another data collection system. Data comparability between the two systems might be a little problematic, but it is hoped that the requirement that the system replicate all functions of the old system will make those problems less severe. In addition all the old data will be ported over to the new HIS. HIS was developed using the Avatar PH off-the-shelf software with significant modifications. This should allow Program Staff and Managers to begin doing more in-depth evaluation because there will be more access to data previously uncollected or unavailable. In addition, improved data reporting functions as well as the ability to run reports on specific items of interest will help with evaluation. In the past, program managers have been stymied because of their inability to access data except through canned reports. The new system's capacity to run ad-hoc reports and to produce electronic reports is seen as a real benefit for evaluation and needs assessment.

G. Technical Assistance

See Form 15 for specific technical assistance requests.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
1. Federal Allocation *(Line1, Form 2)*	16565419	15928291	16616923		16614558	
2. Unobligated Balance *(Line2, Form 2)*	0	0	0		0	
3. State Funds *(Line3, Form 2)*	57445175	57944750	59694226		50812077	
4. Local MCH Funds *(Line4, Form 2)*	0	0	0		0	
5. Other Funds *(Line5, Form 2)*	60139120	66757138	65434182		65575818	
6. Program Income *(Line6, Form 2)*	97036173	102103953	98475392		102103953	
7. Subtotal	231185887	242734132	240220723		235106406	
8. Other Federal Funds *(Line10, Form 2)*	309052426	303753568	318605618		341710716	
9. Total *(Line11, Form 2)*	540238313	546487700	558826341		576817122	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
I. Federal-State MCH Block Grant Partnership	**Budgeted**	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
a. Pregnant Women	57445865	53543233	52840220		51860680	
b. Infants < 1 year old	22744874	25858114	28216263		25045543	

c. Children 1 to 22 years old	109799328	112660305	108688826		109120045	
d. Children with Special Healthcare Needs	26738381	25826844	27190006		25015256	
e. Others	13827429	24063120	22571379		23306956	
f. Administration	630010	782516	714029		757926	
g. SUBTOTAL	231185887	242734132	240220723		235106406	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	103350		101859		112760	
c. CISS	138824		176915		107142	
d. Abstinence Education	0		0		0	
e. Healthy Start	2608484		2597598		2621768	
f. EMSC	0		0		0	
g. WIC	174170170		200421375		220639460	
h. AIDS	0		457900		40268	
i. CDC	7758871		8020589		12225834	
j. Education	0		0		0	
k. Other						
CACFP/SFP	0		90293562		90245482	
CHIP	0		506131		507380	
MCHB	934672		1002168		1158757	
Medicaid FFP	0		3045391		2034819	
SAMHSA	0		0		643034	
SAPT BG	0		37779		37779	
TANF	2758080		2948080		2950000	
Title X (FP)	0		8834550		8386233	
CCDev	0		61721		0	
Soc Svcs BG	0		100000		0	
CACFP	107848178		0		0	
Child Dev. BG	274796		0		0	
Medicaid Admin	2723975		0		0	
Non-Title V Ind Cost	346940		0		0	
SAPT Block Grant	37779		0		0	
SCHIP	497654		0		0	
Title X FP	8850653		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		**FY 2010**		**FY 2011**	
	Budgeted	**Expended**	**Budgeted**	**Expended**	**Budgeted**	**Expended**
I. Direct Health Care Services	96077366	97978632	95072095		94899732	
II. Enabling	90622210	96471027	96911524		93439502	

Services						
III. Population-Based Services	35551267	36773017	38270056		35617454	
IV. Infrastructure Building Services	8935044	11511456	9967048		11149718	
V. Federal-State Title V Block Grant Partnership Total	231185887	242734132	240220723		235106406	

A. Expenditures

Total state partnership expenditures in 2009 were about $11.5 million over 2008. The primary reasons were due to increases in Medicaid expenditures for health services for women and children in local health departments and higher expenditures in the WIC program from formula rebates. These increases were probably due in part to a greater number of persons eligible for Medicaid and WIC services due to the economic downturn.

B. Budget

North Carolina's Maternal and Child Health Block Grant financial management plan assures the compliance with the Title V fiscal requirements.

Section 503 (a)
The state requires that all state match for the grant be budgeted in the same cost center with the relevant federal dollars. Upon expenditure of those pooled dollars, the state draws the appropriate number of federal dollars to reflect the 4:3 federal to state match rate.

Section 503 (c)
Administrative costs are identified in specific cost centers. Typically, these are indirect costs that are charged in the division's cost allocation plan, and certain direct costs for administrative offices. Budgets for these cost centers are summed and compared to the total budget to assure they are not more than 10% of the total grant amount.

Section 505 (a) (3) (A & B)
The state budgets available funds in a series of cost centers called RCC's. These centers are used to group dollars intended for certain types of programs and services. The RCC's are assigned to one or both of the 30% "set aside" categories, and are assessed a percentage of the budget that can be attributable to services in the category. For example, the RCC 5745 consists of allocated funds to local health departments for child health services. We determine the proportion of the funds that are attributed to preventive and primary care service and services for children with special health care needs, then multiply the percentages by the allocation to come up with the respective amounts for each category. This assessment is performed for each RCC in which Title V funds are budgeted, and the sums for the two categories are compared to the total budget to determine compliance.

Section 505 (a) (4)

The maintenance of effort from 1989 is $29,063,379. Total state funds budgeted for MCH programs as shown in Form 2 is $50,812,077. This includes state funds used for matching Title V funds, which for the FY11 application, is $12,462,372.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section “New State Performance Measure Detail Sheets and Data.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.